

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #23b Film #G385 2/26/pc

00070

CERTIFICATE OF DEATH

00070

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gambrills, (rural)	
d. STREET ADDRESS Box 133, Gambrills		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Herbert Middle Thomas Allen		Lost	4. DATE OF DEATH Month January 25 Doy 19 Year 67
S. SEX M	6. COLOR OR RACE W	7. MARITAL STATUS NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-26-99
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		10b. KIND OF BUSINESS OR INDUSTRY construction	9. AGE (In years lost birthday) XX 67 yrs.
13. FATHER'S NAME James Thomas Allen		11. BIRTHPLACE (County & State, or foreign country) Cleveland, Ohio	
14. MOTHER'S MAIDEN NAME Florence May Knott		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes unknown		16. SOCIAL SECURITY NO. 563-22-1655	17. INFORMANT Mrs. Ethel M. Reynolds - same as #2 above Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH	
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>ASHD</i>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Jan 3, 1966, to Jan 25, 1967, that (I) (we) last saw the deceased alive on Jan 3, 1967, and that death occurred at 1A M, from causes and on the date stated above.	
22a. MEDICAL CERTIFICATION		22b. SIGNATURE Dr. Joseph Taler	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 95 Aquahart Road, Glen Burnie, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial		23b. DATE THEREOF 1/26/67	
23c. NAME OF CEMETERY OR CREMATORIAL Lakeview Cemetery		23d. LOCATION (City or Town) (County) (State) Cleveland Cuyahoga Ohio	
24. FUNERAL DIRECTOR Beverly E. Hopping		ADDRESS	
Hopping Funeral Home		25a. REC'D BY REGISTRAR JAN 27 1967	
Annapolis, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00073

CERTIFICATE OF DEATH

00071

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		
o. COUNTY Anne Arundel MARYLAND		o. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 5 days		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) William Francis ATWELL		First William	Middle Francis	
Last ATWELL		4. DATE OF DEATH January 16 1967	Month Day Year	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Oct. 18, 1885		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Dofs Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONTRACTOR		10b. KIND OF BUSINESS OR INDUSTRY BUILDING	11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Robert F Atwell		14. MOTHER'S MAIDEN NAME MINNIE Kirchner		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215 30 3393	17. INFORMANT BERNIE A Ferguson Shadyside Md. Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446X DUE TO Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Nephrosclerosis & syphilis (c)		INTERVAL BETWEEN ONSET AND DEATH 7 days years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. Jan. 16 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Shady Side, Md.	20f. (City or town) (County) (State)
21. I certify that (I) (checkmark) attended the deceased from _____, 19_____, to Jan. 16, 1967 that (I) (checkmark) last saw the deceased alive on Jan. 16 1967 , and that death occurred at _____ M, from causes and on the date stated above.				
22a. SIGNATURE Willard F. Smith		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 3:20 AM 1/16/67	
22c. PHYSICIAN'S NAME (Type) Willard F. Smith, M.D.		22d. ADDRESS Shady Side, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-18-67	23c. NAME OF CEMETERY OR CREMATORIAL Woodfield	23d. LOCATION (City or Town) (County) (State) Galesville, Md
24. FUNERAL DIRECTOR HARDESTY F. H. Galesville, Md		ADDRESS	25a. REC'D BY REGISTRAR JAN 24 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00072

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1		M		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
00072		CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE														
Anne Arundel MARYLAND		MD														
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b														
Pasadena Md yrs																
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS														
Own Home		Rt 9-Box 461														
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year								
DAISY ELLEN BAUER					1-10-67			19								
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS								
F		W			Aug 23, 1890	76 yrs.	Months	Days	Hours	Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY														
Housewife		Home														
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?														
Anne Arundel Co		U.S.														
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME														
Elsey Lee Wade		Vennie Duval														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT		Address										
None				Herbert M. Bauer Sr., Pasadena Md												
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH														
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): H20.1		Congestive Heart Failure														
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)	Coronary Failure													
		DUE TO (c)	a.c.v.d.													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)																
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)						
21. I certify that (I) (this hospital) attended the deceased from 1958, 19, to 1967, 19, that (I) (we) last saw the deceased alive on Dec 66, 19, and that death occurred at 735 M, from the causes and on the date stated above.																
22a. SIGNATURE		22b. DATE SIGNED										1967				
Robert R. Hahn M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>														
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS										Robert R. Hahn P.O. Box Sevenoak				
Burial		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town or county)		(State)								
1/13/67		Meadowridge Cemetery		ELKRIDGE		Md										
24. FUNERAL DIRECTOR		ADDRESS										25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Kirkey Funeral Home, Glen Burnie												DATE JAN 16 1967		Charles Judge		

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00073

CERTIFICATE OF DEATH

00073

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			
a. COUNTY Anne Arundel MARYLAND				a. STATE Maryland Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town).		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
Annapolis				Annapolis		179 West Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM?			
Anne Arundel General Hospital				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day Year
Ida		Louise		BIAS	January	6	1967
S. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
Female	Negro	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	December 23, 1900	66		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)	
Housewife						Annapolis, Maryland	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Eugene Holloway				Frances Johnson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT				Address			
				Walter Bias 179 West St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Pulmonary Embolism INTERVAL BETWEEN ONSET AND DEATH 10 min							
332X							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO (b) Decrease in Blood Clotting 8 days							
DUE TO (c) Cerebral Infarction							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
19							
21. I certify that (I) (this hospital) attended the deceased from 12-26-66 , 19 66 , to 1-6-67 , 19 67 , that (I) (we) last saw the deceased alive on 1-6-67 , 19 67 , and that death occurred at 3:30 A.M. M. from causes and on the date stated above.							
22a. SIGNATURE J. A. Allen				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) AT ALLEY				22d. ADDRESS 62 Cocked Hat St			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 1/10/67	23c. NAME OF CEMETERY OR CREMATORIUM Burial Station Cemetery		23d. LOCATION (City or Town) (County) (State) Annapolis Anne Arundel		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
John Russell Annapolis, Md						Charles Judge	
DATE JAN 10 1967							

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WATER BALANCE

AT000

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00074

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenland Beach		c. LENGTH OF STAY IN 1b 4 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenland Beach		d. STREET ADDRESS 114 Greenland Beach Rd.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 114 Greenland Beach Road						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First MARY	Middle ELIZABETH	Last BLANKENSHIP	4. DATE OF DEATH January 2	Month January	Day 2	Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 14, 1900		9. AGE (In years lost birthday) 66 yrs.	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS. Hours 2				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.						
13. FATHER'S NAME Chaude Hunley		14. MOTHER'S MAIDEN NAME Lola B. Taylor									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Virginia Reed		Address Same					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia											
DUE TO 334X											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MALNUTRITION											
DUE TO											
(c) CEREBRAL ATHERO SCLEROSIS											
INTERVAL BETWEEN ONSET AND DEATH 2 days											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Rheumatoid Arthritis = ankylosing spondylitis.											
20c. TIME OF INJURY Month, Day, Year Hour o. m. 20d. INJURY OCCURRED p. m. 19 While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>								20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (✓) attended the deceased from _____ to _____, that (I) (✓) last saw the deceased alive on 1/2 1967 , and that death occurred 7:35 PM , from the causes and on the date stated above.								1963 to 1/2 1967		1967	
22a. SIGNATURE C. Earl Hill								M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/2/67	
22c. PHYSICIAN'S NAME (Type) C. Earl Hill								22d. ADDRESS Riviera Beach, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 5, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Cemetery		23d. LOCATION (City, town, or county) Bluefield, West Virginia		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE George J. Gonce								ADDRESS 4001 Ritchie Hwy Balto.		25a. REC'D BY REGISTRAR DATE JAN 9 1967	
								25b. REGISTRAR'S SIGNATURE Charles Judge			

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Suburbia

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00075

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (If deceased lived, if institution: Residence before admission) a. STATE <i>P.A.</i> b. COUNTY <i>Somerset</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brooklyn - Baltimore</i>		c. LENGTH OF STAY IN b <i>7 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>179 Meadow Street</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bogintown</i>	
f. STREET ADDRESS <i>-</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Gertrude</i>	First <i>G</i>	Middle <i>Ernestine</i>	Last <i>1</i>
4. DATE OF DEATH <i>1967</i>	Month <i>J</i>	Doy <i>5</i>	Year <i>1967</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 2, 1893</i>
9. AGE (In years last birthday) <i>73 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. DAYS <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Somerset Co., Pa.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>William H. Bittner</i>	14. MOTHER'S MAIDEN NAME <i>Cullen Gove</i>	Address <i>Mr. Mary Schuck, Shady Bay, Pa.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>?</i>	17. INFORMANT <i>Mrs. Mary Schuck, Shady Bay, Pa.</i>	INTERVAL BETWEEN ONSET AND DEATH <i>Death</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterosclerosis</i>			
DUE TO <i>450.0</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			
DUE TO <i>Arterosclerosis</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <i>Shady Bay</i>		(County) <i>Somerset Co.</i>	(State) <i>P.A.</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>E. L. Haight</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. L. Haight</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
Address (Street, city, town, or county) <i>Shady Bay, Somerset Co., Pa.</i>			
22. DATE SIGNED <i>1-8-67</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>1-12-67</i>	23c. NAME OF CEMETERY OR Crematory <i>Shady Bay I.O.O.F.</i>	23d. LOCATION (City or Town) <i>Shady Bay, Somerset Co., Pa.</i>
24. FUNERAL DIRECTOR <i>Arthur H. Haight, Hyattsville, Md.</i>	ADDRESS <i>Hyattsville, Md.</i>	25a. RECD BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
DATE JAN 13 1967		DATE JAN 13 1967	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00076

CERTIFICATE OF DEATH

00076.

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Aruhdel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 7 Monument St.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First William	Middle Henry	Last BROWN
4. DATE OF DEATH January 5 1967	Month January	Doy 5	Year 1967
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 25, 1898
9. AGE (In years last birthday) 68 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.	13. FATHER'S NAME William H Brown Jr.		
14. MOTHER'S MAIDEN NAME Gane Jennings	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service Unknown		
16. SOCIAL SECURITY NO.	17. INFORMANT Edna Brown 7 Monument St.	Address	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO 42201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerotic cardiovascular disease DUE TO (c)
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) multiple myocardia, hypotension, circaria	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19	19 66		
21. I certify that (I) <input type="checkbox"/> attended the deceased from Jan. 5, 1967 , to Jan. 5, 1967 , thot (I) <input type="checkbox"/> last saw the deceased alive on Jan. 5, 1967 , and that death occurred at 9:30 AM M, fram causes ond an the date stoted above.	22b. DATE SIGNED 1/1/67		
22a. SIGNATURE Robert Biern	M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) Robert Biern, M.D.	22d. ADDRESS 121 Cathedral St., Annapolis, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1-9-1967	23b. DATE THEREOF 1-9-1967	23c. NAME OF CEMETERY OR CREMATORIAL St. Anne's Cemetery	23d. LOCATION (City or Town) (County) (State) Annapolis, Md.
24. FUNERAL DIRECTOR William Reesett, Jr.	ADDRESS 121 Cathedral St., Annapolis, Md.	25a. REC'D BY REGISTRAR 1/10/67	25b. REGISTRAR'S SIGNATURE Judge
25c. DATE JAN 10 1967			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00077

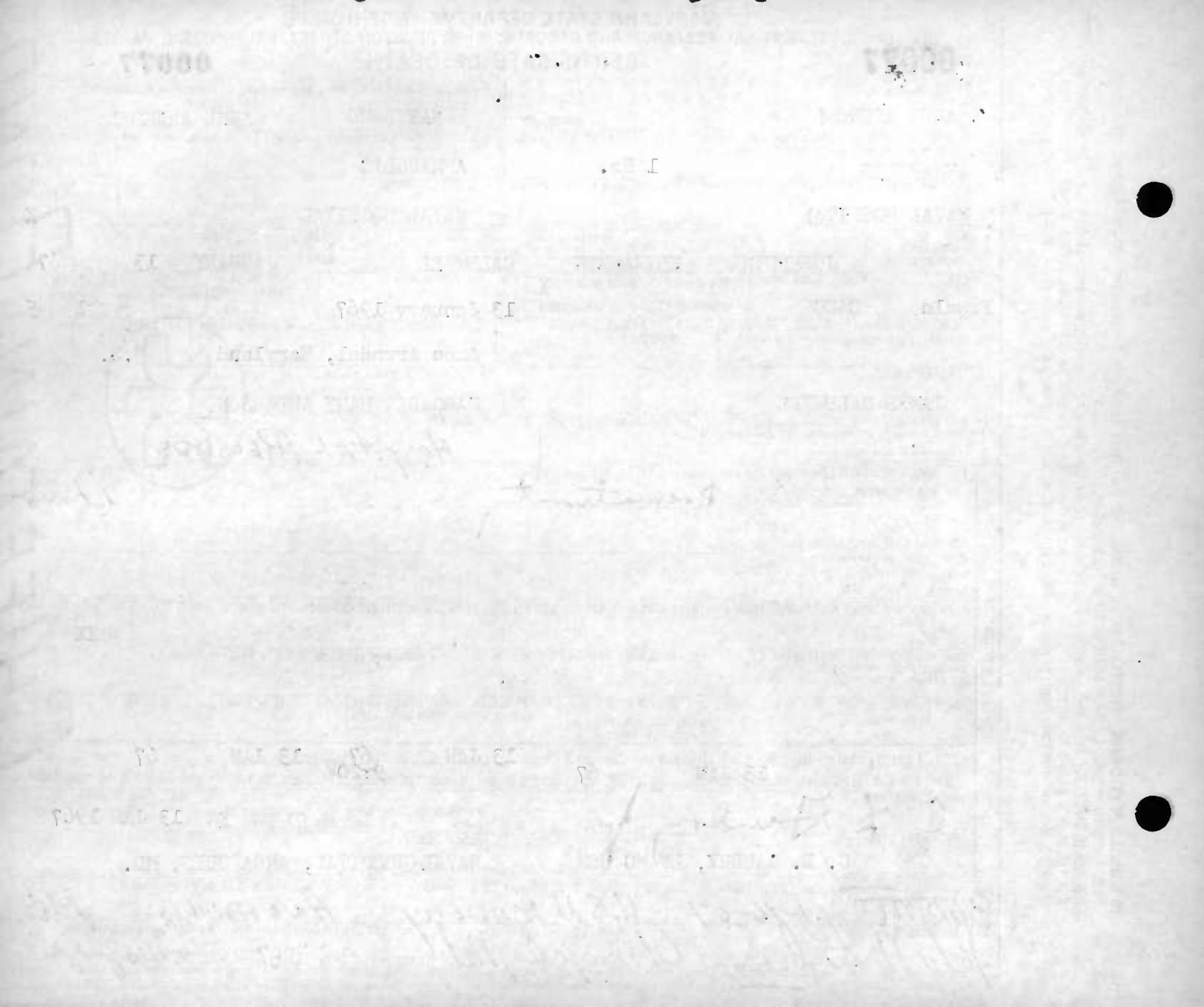
CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. LENGTH OF STAY IN 1b 1 Hr.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) NAVAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First JOSEPHINE	Middle ELIZABETH	Last CALDWELL
4. DATE OF DEATH	Month JANUARY	Day 13	Year 1967
5. SEX Female	6. COLOR OR RACE CAUC	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 13 January 1967
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Anne Arundel, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JAMES CALDWELL	14. MOTHER'S MAIDEN NAME MARGARET MARY ANDERSON		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>	16. SOCIAL SECURITY NO.	17. INFORMANT	Address <i>Hospital Records</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			
INTERVAL BETWEEN ONSET AND DEATH 1 hour			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from 13 JAN 1967 to 13 JAN 1967 , that (I) (we) last saw the deceased alive on 13 JAN 1967 , and that death occurred at 9:20P M, from the causes and on the date stated above.			
22a. SIGNATURE <i>C. L. Gaudry, Jr.</i>		22b. DATE SIGNED 13 JAN 1967	
22c. PHYSICIAN'S NAME (Type) C. L. GAUDRY, LT MC USN		M.D. ATTENDING PHYS. <input type="checkbox"/> 22d. ADDRESS NAVAL HOSPITAL, ANNAPOLIS, MD.	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-16-67	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS U.S.N ACADEMY		23d. LOCATION (City, town or county) (State) Annapolis MD.	
24. FUNERAL DIRECTOR John M. Taylor Sons Annapolis, Md.		25a. REC'D BY REGISTRAR DATE JAN 18 1967	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00078

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie			c. LENGTH OF STAY IN lb 		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena			d. STREET ADDRESS 323 Hickory Point Rd.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) N. Arundel Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) CARMELO			First FRANK	Middle CATALDI, Sr.	4. DATE OF DEATH Month January Day 14 Year 1967
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 8, 1921	9. AGE (In years last birthday) 45 yrs.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Used Car Dealer(Ret.)			10b. KIND OF BUSINESS OR INDUSTRY Self Empolyed		
11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Anthony Cataldi			14. MOTHER'S MAIDEN NAME Mary Busso		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. 214-18-6359		
17. INFORMANT Mrs. Eleanor Cataldi (wife)			Address Same as #2		
18. CAUSE OF DEATH (Enter only one cause per line, far (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X			INTERVAL BETWEEN ONSET AND DEATH 1 year		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause { last. (b) DUE TO (c) DUE TO			<i>Carcinoma of the larynx with metastases to the brain</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) None			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1/15/67	20f. (City or town) (County) (State) 1/15/67
21. I certify that (I) (this hospital) attended the deceased from 1/13/67 , to 1/15/67 , that (I) (we) last saw the deceased alive on 1/13/67 , and that death occurred at 1A M , from causes and on the date stated above.					
22a. SIGNATURE R.M. McLaughlin			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 1/17/67
22c. PHYSICIAN'S NAME (Type) R.M. McLaughlin			22d. ADDRESS 323 Hickory Point Rd. Pasadena, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 19, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Glen Haven Mem. Park		23d. LOCATION (City or Town) (County) (State) Glen Burnie, Maryland
24. FUNERAL DIRECTOR Eugene B. Fleming		ADDRESS Singleton Funeral Home		25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE J. Charles Judge
VR A15 (4) 20 M 1/66		DATE JAN 19 1967			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH			00080												
1. PLACE OF DEATH a. COUNTY <i>A. Co.</i>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>A. Co.</i>				3. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Severna Park</i>				4. DATE OF DEATH Month Day Year <i>1 - 1 1967</i>															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i>				c. LENGTH OF STAY IN 1b <i>10 years</i>				d. STREET ADDRESS <i>Re 2 Box 699 - St. Martin Lane</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print)		First <i>ELIZABETH</i>		Middle <i>CHICK</i>		Last		4. DATE OF DEATH Month Day Year <i>1 - 1 1967</i>		5. SEX <i>FEM.</i>		6. COLOR OR RACE <i>WHITE</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3-15-85</i>		9. AGE (In years last birthday) <i>81 yrs.</i>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>—</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>DR</i>		11. BIRTHPLACE (County & State, or foreign country) <i>—</i>		12. CITIZEN OF WHAT COUNTRY? <i>BA</i>	
13. FATHER'S NAME <i>— KALINCSAK</i>		14. MOTHER'S MAIDEN NAME <i>—</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>MARGARET BENINGER - ABOVE</i>		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Liposarcoma, left supra-clavicular area</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 mo.</i>													
Gconditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. <i>197.9</i>		DUE TO (b) DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Aug. 19 57, to Jan. 19 67, that (I) (we) last saw the deceased alive on Dec. 19 66, and that death occurred at 9:30 AM, from the causes and on the date stated above.		22a. SIGNATURE <i>Francis I. Codd</i>		22b. DATE SIGNED <i>1-2-67</i>											
22c. PHYSICIAN'S NAME (Type) <i>Francis I. Codd M.D.</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS <i>Severna Park, Maryland</i>		23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 1-4-67</i>		23b. DATE THEREOF <i>1-4-67</i>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Glen Haven</i>		23d. LOCATION (City, town or county) (State) <i>Glen Burnie, Md</i>															
24. FUNERAL DIRECTOR <i>Robert S. Lawrence, Severna Ph. M.D.</i>		ADDRESS <i>REBERT S. BAKER INC.</i>		25a. REG'D BY REGISTRAR DATE <i>JAN 4 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>																					

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12/22/10 10:00:00 AM

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00080

CERTIFICATE OF DEATH

00081

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN lb 3 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 607 Pennsylvania Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) #26249		First George	Middle	Last Colbert	4. DATE OF DEATH Month 1 Day 5 Year 1967	Month	Day
S. SEX Male	6. COLOR OR RACE Negro	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 4/12/1912	9. AGE (In years last birthday) yrs. 54	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia						INTERVAL BETWEEN ONSET AND DEATH	
491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		DUE TO DUE TO DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Chronic Brain Syndrome due to Convulsive Disorder (Epilepsy)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) -----		20c. TIME OF INJURY Month, Day, Year Hour o.m. ----- p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) -----	
21. I certify that (I) (this hospital) attended the deceased from 10/18/1963 , to 1/5/1967 , that (I) (we) last saw the deceased alive on 1/5/1967 , and that death occurred at 8:48 M, from causes and on the date stated above.							
22a. SIGNATURE L. Benedict, M.D.		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 1/5/67	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.		22d. ADDRESS Crownsville State Hospital, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial Jan 7/67		23b. DATE THEREOF Jan 7/67		23c. NAME OF CEMETERY OR CREMATORIAL Mt Calvary Cem		23d. LOCATION (City or Town) (County) (State) A County Md	
24. FUNERAL DIRECTOR Spaul T. Eickam		ADDRESS 1129 N. Carolina St		25a. REC'D BY REGISTRAR DATE JAN 9 1967		25b. REGISTRAR'S SIGNATURE Spaul T. Eickam	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

00082

00082

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel General Hospital		d. STREET ADDRESS 1529 Ingalls Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle ATWELL		4. DATE OF DEATH Month 1 Doy 10 Year 1967	
5. SEX Male White		6. COLOR OR RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 10/6/27		9. AGE (In years lost birthday) 39 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME JOSEPH P. CRAWFORD, SR.		14. MOTHER'S MAIDEN NAME CLARA KIMBREW	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) YES		16. SOCIAL SECURITY NO. 17. INFORMANT Address MARY E. CRAWFORD GLEN BURNIE, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Tamponade</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Laceration of Aorta</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH:		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in auto-fixed object accident	
20c. TIME OF INJURY Month, Day, Year 8:30 a.m. 9:30 P.m. 1 10 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street
		20f. (City or town) (County) (State) Anne Arundel Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Rudiger Breitenecker</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) Rudiger Breitenecker, M.D.	
EXAMINER'S NAME (Type) Rudiger Breitenecker, M.D.		22. DATE SIGNED 1/11/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1/16/67	
23c. NAME OF CEMETERY OR CREMATORIAL ARLINGTON NATIONAL CEM.		23d. LOCATION (City or Town) (County) (State) ARLINGTON, VIRGINIA	
24. FUNERAL DIRECTOR HOWARD H. HUBBARD 4107 WILKENS AVE. 21229		ADDRESS	
		25a. REC'D BY REGISTRAR DATE 13 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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FOR STATE
HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00082

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00083

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal. File page 5 in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN lb				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North A r undel Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
Rt. 2, Box 300		d. STREET ADDRESS				
3. NAME OF DECEASED (Type or print) KERMIT		First E.	Last CREWS			
4. DATE OF DEATH January 14 1967		Month	Day Year			
5. SEX Male		6. COLOR OR RACE White	7. MARRIED WIDOWED	8. DATE OF BIRTH Feb. 17, 1910	9. AGE (In years lost birthday) 56 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Station Mechanic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Winston-Salem, N. C.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Oscar E. Crews		14. MOTHER'S MAIDEN NAME Mary Phipps				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> No None		16. SOCIAL SECURITY NO.		17. INFORMANT Frank Voglar Funeral Home		Address Winston-Salem North Carolina
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 812.4 IMMEDIATE CAUSE (a) Multiple Extreme Injuries. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause { lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH:		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by motor vehicle				
20c. TIME OF INJURY Month, Day, Year Hour XXX 6:00 p.m. 1/ 14 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Millersville A.A. Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 1/15/67		
23a. BURIAL, CREMATION, REMOVAL (Specify) 1/16/1967		23b. DATE THEREOF 1/16/1967		23c. NAME OF CEMETERY OR CREMATORIAL Bunker Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Forsyth County, N. C.
24. FUNERAL DIRECTOR W.M.J. Jackson & Sons		ADDRESS Balto, MD		25a. REC'D BY REGISTRAR DATE JAN 17 1967		25b. REGISTRAR'S SIGNATURE Charles Petty

£8000

£3000

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00083

CERTIFICATE OF DEATH

00084

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN lb <u>2mos. 2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>923 Dantry Ct.</u>			
3. NAME OF DECEASED (Type or print) <u>3-#33947</u>		First <u>Anna</u>	Middle <u>Marie</u>	Last <u>Cummings</u>	4. DATE OF DEATH Month <u>1</u>	Day <u>29</u>	Year <u>1967</u>
S. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>June 28, 1925</u>	9. AGE (In years last birthday) <u>41</u> yrs.	IF UNDER 1 YEAR Months <u> </u>	IF UNDER 24 HRS. Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Johnstown, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>William Cummings</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>198-20-4243</u>		17. INFORMANT <u>Hospital Records</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Bronchopneumonia</u> DUE TO (c) <u>Arteriosclerotic Cardiovascular Disease</u>							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>11/27</u> , 19 <u>66</u> to <u>1/29</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/29</u> , 19 <u>67</u> , and that death occurred at <u>A.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Merle J. Benedict</u>							
22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M. D.</u>		22b. ADDRESS <u>Crownsville State Hospital, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-1-1967</u>		23c. NAME OF CEMETERY OR CREMATORIAL PK. <u>Glen Haven Memorial Pk.</u>		23d. LOCATION (City or Town) (County) (State) <u>Ritchie Hwy., A.A.C.O., Md.</u>	
24. FUNERAL DIRECTOR <u>George J. Gonce-4001 Ritchie Hwy., Baltimore</u>				ADDRESS		25a. RECD BY REGISTRAR <u> </u>	
						25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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X

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00084

CERTIFICATE OF DEATH

00085

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 1 mo. 7 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> Severn.	
3. NAME OF DECEASED (Type or print) Peter		First White	Middle DARAGO
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH June 29, 1885		9. AGE (In years last birthday) 81 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even retired) Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY Mining	
11. BIRTHPLACE (County & State, or foreign country) Hungary		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME John Darago		14. MOTHER'S MAIDEN NAME Elizabeth Szabo	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Theresa Darago #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism			
465X DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Regional Enteritis w. Ulceration, Bowel w. Hemorrhage, Bone w. Osteomyelitis, Jaunies's syndrome			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) Richard N. Peeler attended the deceased from 11/26 , 19 66 , to Jan. 3 , 19 67 , that (I) (He) last saw the deceased alive on Jan. 3 , 19 67 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE Richard N. Peeler		9:40 PM M.D. ATTENDING MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 1/4/67	
22c. PHYSICIAN'S NAME (Type) Richard N. Peeler, M.D.		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-5-67	
23c. NAME OF CEMETERY OR CREMATORIAL Mt. Calvary Cemetery		23d. LOCATION (City or Town) (County) (State) Steubenville Ohio	
24. FUNERAL DIRECTOR John M. Taylor & Sons Annapolis, Md.		25a. REC'D BY REGISTRAR DATE JAN 5 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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Labour force

benefits

Labour force

Labour force - daily average 1.0 5

Labour force

To calculate the effect of a change in the fiscal factors Labour force

Labour force

benefits

Labour force

Labour force - daily average 1.0 5

To calculate the effect of a change in the fiscal factors Labour force

Labour force - daily average 1.0 5

To calculate the effect of a change in the fiscal factors Labour force

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Labour force - daily average 1.0 5

To calculate the effect of a change in the fiscal factors Labour force

Labour force - daily average 1.0 5

12
1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00085

CERTIFICATE OF DEATH

00086

1. PLACE OF DEATH a. COUNTY	Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE MD	b. COUNTY Co.		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	Severna Park		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	Severna Park Md 211		
d. LENGTH OF STAY IN b.			d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
214 Oak Ave			214 Oak Ave			
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month Day Year	
Female	Delbert Maurice Davis		Dec 3, 1895	1-25-67	19 19	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.	
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Dec 3, 1895	71 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?			
Banker	Bank	Baltimore Md U.S.				
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	Address				
David S. Davis	Lily Davis					
15. WAS DECEASED EVER IN U.S. ARMEO FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	INTERVAL BETWEEN ONSET AND DEATH		
Yes	W.W.I 215075013	Esther Davis	Acute myocardial infarction			
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.	DUE TO (b)	A.C. W.D.				
	DUE TO (c)	Sen cert				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
19						
21. I certify that (I) (this hospital) attended the deceased from Dec 1958, 19, to 1967, 19, that (I) (we) last saw the deceased alive on Dec 1966, and that death occurred at 3:45 PM, from the causes and on the date stated above.	22a. SIGNATURE Robert R. Hahn	ATTENDING M.D. PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 1-23-67	
22c. PHYSICIAN'S NAME (Type)	Robert R. HAHN	22d. ADDRESS 80. Box 73 Severna Park				
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 1-30-67	23c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat'l Cemetery Va.	23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR Robert J. Bernanco, Sevna Park, Md	ADDRESS	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE			
		DATE JAN 31 1967				
ROBERT J. BERNANCO						

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00086

CERTIFICATE OF DEATH

00087

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>A.A. Co.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>M.D.</i>		b. COUNTY <i>A.A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		d. STREET ADDRESS <i>157 Prince George St.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>157 Prince George St.</i>				d. STREET ADDRESS <i>157 Prince George St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>MABEL</i>	Middle <i>M.</i>	Last <i>DAVIS</i>	4. DATE OF DEATH Month <i>1</i>	Day <i>18</i>	Year <i>1967</i>
S. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-20-1888</i>	9. AGE (In years last birthday) yrs. <i>78</i>	IF UNDER 1 YEAR Months <i></i>	IF UNDER 24 HRS. Days <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOME</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>HOUSEWIFE</i>		11. BIRTHPLACE (County & State, or foreign country) <i>CORONADO, CAL.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>JOHN D. MATHEWSON</i>		14. MOTHER'S MAIDEN NAME <i>MARY NEVILLE</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Mrs. R. L. MOORE JR.</i>		Address <i>R.T.D. #2 AMBERLEY, MD.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i>		DUE TO (b) <i>Hemorrhage, Cerebral</i>		DUE TO (c) <i>Arteriosclerotic Heart Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>unknown</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <i>CORNHILL ST. ANNAPOLIS, MD</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>1-18-</i> , 19 <i>67</i> , to <i>—</i> , 19 <i>—</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that death occurred at <i>431 M.</i> from causes and on the date stated above.							
22o. SIGNATURE <i>W.M. P. Stephens</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>1-19-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>W.M. P. Stephens</i>		22d. ADDRESS <i>CORNHILL ST. ANNAPOLIS, MD</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>1-20-67</i>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>U.S. NAVAL ACADEMY</i>		23d. LOCATION (City or Town) County (State) <i>Annapolis A.A. M.D.</i>	
24. FUNERAL DIRECTOR <i>John M. Taylor & Sons Annapolis, Md.</i>				25a. REC'D. BY REGISTRAR <i>JAN 24 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

1947 MARSHAL ISLANDS STATEMENT
1947 MARSHAL ISLANDS STATEMENT

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1947 MARSHAL ISLANDS STATEMENT

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH												
						00088						
<p>1. PLACE OF DEATH a. COUNTY <u>A. Co</u> MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u></p> <p>c. LENGTH OF STAY IN lb <u>6 months</u></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>131 Round Bay Rd.</u></p>						<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>A.</u></p> <p>c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Severna Park</u></p> <p>d. STREET ADDRESS <u>131 Round Bay Rd</u></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>						
3. NAME OF DECEASED (Type or print) <u>MARIE</u>			First <u>D</u>	Middle <u>Illes</u>	Last <u>DeRuy</u>	4. DATE OF DEATH Month <u>1</u> Day <u>- 15</u> Year <u>1967</u>						
S. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-7-82</u>			9. AGE (In years lost birthday) <u>84 yrs.</u>	IF UNDER 1 YEAR Months <u></u>	IF UNDER 24 HRS. Days <u></u>	Hours <u></u>	Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housenurse</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Belgium</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MATURE NAME <u>Unknown</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u></u>			17. INFORMANT <u>Hugo Coelius</u>	Address <u>Alve</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)			PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <u>422.1</u> DUE TO (b) <u>Cerebral thromosis</u> Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (c) <u>Arteriosclerotic Cardiovascular disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)									
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m. <u></u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) <u>Severna Park</u> (County) <u>Md</u> (State) <u></u>			
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at <u>home</u> M, from causes and on the date stated above.												
22a. SIGNATURE <u>Ray M. Smith</u>			M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>1-15-67</u>						
22c. PHYSICIAN'S NAME (Type) <u>RAY M. SMITH M.D.</u>			22d. ADDRESS <u>SEVERNA PARK Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-18-67</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>St. Mary's Cem.</u>		23d. LOCATION (City or Town) <u>Annapolis</u> (County) <u>A.F.</u> (State) <u>Md.</u>						
24. FUNERAL DIRECTOR <u>Robert Barrance</u>		ADDRESS <u>Severna Ph. Rd.</u>		25a. REC'D BY REGISTRAR <u>JAN 18 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>						
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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item o Film G385 1/26/67 mh

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00089

1. PLACE OF DEATH a. COUNTY <i>A.A.C.O.</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb c. CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town) <i>Mulberry Rd - Hanover</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>O.O.A.-NORTH ARUNDEL</i>		d. STREET ADDRESS <i>7412 - Mulberry Rd</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Blanche</i>		First <i>9</i>	Middle <i>Dreier</i>
4. DATE OF DEATH Month <i>1</i>	Month <i>21</i>	Doy <i>1967</i>	Year
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-18-95 1894</i>
9. AGE (In years last birthday) <i>72 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	12. BIRTHPLACE (State or foreign country) <i>Baltimore, md.</i>
13. FATHER'S NAME <i>William Stable</i>	14. MOTHER'S MAIDEN NAME <i>Tannie Green</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>NONE</i>	17. INFORMANT <i>William Dreier - Same as above</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerosis generalized</i> DUE TO <i>45.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) DUE TO DUE TO DUE TO	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>E. L. Johnson Jr.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>1-21-67</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1/24/67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Loudon Park Cemetery Baltimore</i>
23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <i>Robert Purple</i>		ADDRESS <i>Singleton Funeral Home / Glen Burnie</i>	25a. RECEIVED BY REGISTRAR DATE JAN 24 1967
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

00089

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00090

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PMB. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anco MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Mass	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Quesn Burnie		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elizabeth Van Praag		First E	Middle I
4. DATE OF DEATH Lost Dudley		Month 1	Day 19
5. SEX F		6. COLOR OR RACE W	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH 4-10-98		9. AGE (In years lost birthday) 68 yrs.	10. IF UNDER 1 YEAR Months 0
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Bookkeeper		11. KIND OF BUSINESS OR INDUSTRY New York City, New York	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Porter Van Praag		14. MOTHER'S MAIDEN NAME Grace Coolidge	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 019-10-5421	17. INFORMANT Address Hospital Records
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular disease DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 3 hours.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Hatch</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. Frankoff</i>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Framingham, Mass.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 22, 1967	23c. NAME OF CEMETERY OR CREMATORIUM Edgell Grove
23d. LOCATION (City or Town) (County) (State)		23e. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR William J. Pickering & Sons North & Pa. Aves.		ADDRESS 15 Charles Street	25a. REC'D BY REGISTRAR Charles Judge
		25b. REGISTRAR'S SIGNATURE	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

00091

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE	
Anne Arundel MARYLAND		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Sherod	Middle Leaphart
		Last EARLE	4. DATE OF DEATH January 31
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
		WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH March 13, 1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER		9. AGE (In years last, birthday) 66 yrs.	
		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
10c. BIRTHPLACE (County & State, or foreign country) JACKSONVILLE		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME SHEROD L. EARLE		14. MOTHER'S MAIDEN NAME MARY COULTER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Ruth EARLE #2	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH 24 hours	
4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE HEART DISEASE			
(c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jun 1960 , to 1/31 1967 , that (I) (we) last saw the deceased alive on 1/31 1967 , and that death occurred at 7:10 P.M. M. from causes and on the date stated above.		22b. DATE SIGNED 2-1-67	
22c. PHYSICIAN'S NAME (Type) Sherod L. Beck		22d. ADDRESS Franklin St. Annapolis, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-3-67	
		23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln	
24. FUNERAL DIRECTOR John M. Taylor & Sons Annapolis, Md.		23d. LOCATION (City or Town) (County) (State) RAEDENSBURG MD.	
		25a. RECEIVED BY REGISTRAR FEB 6 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please, remove carbon papers. Pages 1 and 2, director, page 3, should be detached for use as the burial-transit permit, then please, remove carbon papers. Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

00094

CERTIFICATE OF DEATH

00092

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL	2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANNAPOLIS	c. LENGTH OF STAY IN 1b 4 days				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) NAVAL HOSPITAL	e. STREET ADDRESS BOX 33				
3. NAME OF DECEASED (Type or print) HARLEY ALLEN	4. DATE OF DEATH Month Day Year JANUARY 19 1967				
5. SEX MALE	6. COLOR OR RACE CAUC	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1 JULY 1900	9. AGE (in years last birthday) 66 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min. 0 0 0 0
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	11. BIRTHPLACE (County & State, or foreign country) E. SPENCER N. CARLOINA	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME JOHN FRANKLIN EDWARDS	14. MOTHER'S MAIDEN NAME MARY BRACKON				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES	16. SOCIAL SECURITY NO. 32 213-34-3104	17. INFORMANT WIFE	Address BOX 33 GALESVILLE, MARYLAND		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broadchogenic Causinoma</i>				INTERVAL BETWEEN ONSET AND DEATH 162.1	
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.		(b)			
		DUE TO			
		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) USNH ANNAPOLIS, MARYLAND	(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 16 JAN 1967 , to 19 JAN 1967 , that (I) (we) last saw the deceased alive on 19 JAN 67 19 67 , and that death occurred at 1125A , from the causes and on the date stated above.					
22a. SIGNATURE <i>William P. Arentzen</i>	22b. DATE SIGNED 19 JAN 67				
22c. PHYSICIAN'S NAME (Type) W. P. ARENTZEN, CAPT MC USN	ATTENDING M.D. PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan 23, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Arlington National	23d. LOCATION (City, town or county) Arlington, Va.	(State)	
24. FUNERAL DIRECTOR Harshesty Funeral Home, Galesville, Md	ADDRESS	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE JAN 23 1967	DATE	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00092

CERTIFICATE OF DEATH

00093

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 3 should be detached for use as the burial/transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial/transit or removal, and any event within 72 hours after death.

1. PLACE OF DEATH Anne Arundel		Item 9 Film 0385 1/26/67		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)	
a. COUNTY		MARYLAND		a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie,	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) North Arundel Hospital				d. STREET ADDRESS 116 Carroll Rd. Carroll Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Mabel	Middle E.	Last Ellis	4. DATE OF DEATH 1	Month Day Year 20 1967
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-11-91	9. AGE (In years last birthday) 75 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret		10b. KIND OF BUSINESS OR INDUSTRY Bakery		11. BIRTHPLACE (County & State, or foreign country) Anne Arundel, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME George E. Britton		14. MOTHER'S MAIDEN NAME Elizabeth Coleburn			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> NO		16. SOCIAL SECURITY NO. 216-14-7088		17. INFORMANT Roy Ellis - Same as # 2 Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157X Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		Cerebral thrombosis. Carrying on a very heavy generalized arteriosclerosis.		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO (b) DUE TO (c)		partial small bowel obstruction with uremia			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 16</u> , 1961, to <u>Jan. 20</u> , 1967, that (I) (we) last saw the deceased alive on <u>Jan. 10</u> 1967, and that death occurred at <u>9:40 AM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>Edmond I. Moushakoff</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Edmond I. Moushakoff</u>		22d. ADDRESS <u>Ridgeview, Glen Burnie, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/25/67		23c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Cemetery	
24. FUNERAL DIRECTOR <u>R. Russel</u> Singleton Funeral Home/Glen Burnie, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 24 1967	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

00093

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00094

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

5 may be retained for your files.

1. PLACE OF DEATH a. COUNTY <i>AFCO</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hempstead</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harwood</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Anne Arundel General</i>		d. STREET ADDRESS <i>82-2</i>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Sophie N. Frueck</i>		First <i>Sophie</i>	Middle <i>N</i>
4. DATE OF DEATH <i>1967</i>	Month <i>1</i>	Doy <i>9</i>	Year <i>1967</i>
S. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>1877</i>		9. AGE (In years last birthday) <i>90?</i> yrs.	
10. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>West River, Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Edgar Shepherd</i>	
14. MOTHER'S MAIDEN NAME <i>Agnes McConey</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Sophie N. Chauay</i> Address <i>Harwood, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchitis pneumonia</i> DUE TO <i>Cirrhosis</i> 12-22-66 (b) <i>Cerebralclerosis</i> 10 DUE TO <i>Cerebral thrombosis</i> 1-9-67 (c) <i>Cerebral thrombosis</i>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH <i>None</i>	
20a. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>See above</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>See above</i>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 12-22-1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>
20f. (City or town) <i>Harwood AFCO-110</i>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>J. L. Harwood</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. L. Harwood</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <i>Owensville, MD</i>		22. DATE SIGNED <i>1-9-67</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1-11-67</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Christ Church</i>		23d. LOCATION (City or Town) (County) (State) <i>Owensville, MD</i>	
24. FUNERAL DIRECTOR <i>Bernard Hardesty, Middleville, MD</i>		ADDRESS	
25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
DATE <i>JAN 20 1967</i>			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

M

CERTIFICATE OF DEATH

Reg. Dist. No.

00095

00094

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be attached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Anne Arundel</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Owings Mills</i>		c. LENGTH OF STAY IN 1b <i>67 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Owings Mills</i>		d. STREET ADDRESS <i>P.O. Box 53</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>None</i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Daisy Lee</i>		First	Middle	Last	4. DATE OF DEATH <i>October 19 1967</i>	Month	Day	Year			
5. SEX <i>F</i>		6. COLOR OR RACE <i>Blk</i>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>3-26-03</i>	9. AGE (In years lost/birthday) yrs. <i>63</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>19</i>	Hours <i>10</i>	Min. <i>7</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Private Home</i>		11. BIRTHPLACE (State or foreign country) <i>USA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
13. FATHER'S NAME <i>Val. Jones</i>				14. MOTHER'S MAIDEN NAME							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Carl Stanton Harwood, M.D.</i>		Address <i>101 Bay</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Hyper tension Cardiac Disease</i>									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>3-10-69</i>		20f. (City or town) <i>T-19-67</i>		(County) <i>140</i>	(State) <i>M.D.</i>		
21. I certify that I attended the deceased from <i>12-14-65</i> , 19 <i>65</i> , to <i>1-14-67</i> , 19 <i>67</i> , that I last saw the deceased alive on <i>12-14-65</i> , 19 <i>65</i> , and that death occurred at <i>140</i> M, from the causes and on the date stated above.										ADDRESS (Street, city or town, state) <i>101 Collected St</i>	DATE SIGNED <i>1-14-67</i>
ACTUAL SIGNATURE <i>Aris T. Allen</i>		PHYSICIAN'S NAME (Type) <i>ARIS T. ALLEN</i>									
22a. BURIAL CREMATION REMOVAL (Specify) <i>Jan. 23, 1967</i>		22b. DATE THEREOF <i>Jan. 23, 1967</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Churchton Cemetery</i>		22d. LOCATION (City, town, or county) <i>Churchton</i>		(State) <i>Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>John B. Johnson</i>		ADDRESS <i>Ann Rd</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 23 1967</i>		24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

DEPARTMENT OF HEALTH - STATE OF MASSACHUSETTS

CERTIFICATE OF DEATH

Amelia Lovell

Amelia Lovell

18028

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00095

00096

1. PLACE OF DEATH:

a. COUNTY

Anne Arundel

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Glen Burnie

c. LENGTH OF STAY IN lb

DOA

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

North Arundel Hospital

**3. NAME OF DECEASED
(Type or print)**

First Charles

Middle Henry

Last Fox

4. DATE OF DEATH

Jan.

7,

1967

5. SEX

6. COLOR OR RACE

Male

White

7. MARRIED NEVER MARRIED

B. DATE OF BIRTH

WIDOWED

DIVORCED

19 Dec. 1904

9. AGE (In years last birthday)

62 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Ironworker

10b. KIND OF BUSINESS OR INDUSTRY

Shipyard

11. BIRTHPLACE (County & State, or foreign country)

Milton, Pa.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles E. Fox

14. MOTHER'S MAIDEN NAME

Clara B.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

No

16. SOCIAL SECURITY NO.

162-05-0832

17. INFORMANT

Mrs. Jennie D. Fox, same as 2

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Acute Coronary Thrombosis

INTERVAL BETWEEN
ONSET AND DEATH

Sudden

420.1
DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

Angina Pectoris

DUE TO

(c)

Arteriosclerosis

2 yrs.

5 yrs.

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

None

19. WAS AUTOPSY PERFORMED?
YES NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)

No injury

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19

20d. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

White Not White
at work at work

21. I certify that (I) (this hospital) attended the deceased from 16 August 1965 to 7 Jan. 1967, that (I) (we) last saw the deceased alive on 6 Jan. 1967, and that death occurred at 10 PM, from the causes and on the date stated above.

22a. SIGNATURE

H-F. Manuzak

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED

9 Jan. 1967

22c. PHYSICIAN'S NAME (Type)

Hubert F. Manuzak, M. D.

22d. ADDRESS

425 Ritchie Hwy. S. E., Glen Burnie

23a. BURIAL, CREMATION
REMOVAL (Specify)

Burial

23b. DATE THEREOF

10 Jan. 1967

23c. NAME OF CEMETERY OR CREMATORIUM

Harmony Church Yard

23d. LOCATION (City, town or county)

(State)

Milton, Pa.

24 FUNERAL DIRECTOR'S SIGNATURE

Kirkley Funeral Home, Glen Burnie, Md.

ADDRESS

25e. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE JAN 10 1967

Charles Juge

26000

2600

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00096

CERTIFICATE OF DEATH

00097

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician. Page 4 may be retained by the hospital or attending physician. Director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
o. COUNTY Anne Arundel		o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN lb 111111	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		d. STREET ADDRESS 606 Jersey Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James		First x W.	Middle Gaylor
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 5-31-1987		9. AGE (In years lost birthday) 79 yrs.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter (Ret.)		10b. KIND OF BUSINESS OR INDUSTRY Md. Dry Dock	
11. BIRTHPLACE (County & State, or foreign country) Penna. (Weatherly)		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel Gaylor		14. MOTHER'S MAIDEN NAME Jennie Strutters	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No none		16. SOCIAL SECURITY NO. 185-09-4307	
17. INFORMANT Mrs. Pearl S. Gaylord (wife)		Address Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 1978		INTERVAL BETWEEN ONSET AND DEATH 4 yrs	
DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause { lost.			
(b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Glen Burnie
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1-8 , 19 67 , to 1-11 , 19 67 , that (I) (we) last saw the deceased alive on 1-10 , 19 66 , and that death occurred at Glen Burnie M, from causes and on the date stated above.			
22a. SIGNATURE Ernest A. Leipold		22b. DATE SIGNED 1-11-67	
22c. PHYSICIAN'S NAME (Type) Ernest A. Leipold M.D.		22d. ADDRESS Glen Burnie, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 14, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Freeland Cemetery
23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR Richard V. Singleton		ADDRESS Glen Burnie, Md.	25a. REC'D BY REGISTRAR DATE JAN 15 1967
25b. REGISTRAR'S SIGNATURE James Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00098

00097

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater 02-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 3525 South River Terrace	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Merrill	Middle Alexander	Last GERHAB
4. DATE OF DEATH	Month January	Day 12	Year 1967
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>
8. DATE OF BIRTH June 10, 1891	9. AGE (In years last birthday) 75 yrs.	10. KIND OF BUSINESS OR INDUSTRY Rep. Auto Parts	11. BIRTHPLACE (County & State, or foreign country) Philadelphia Pennsylvania
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk	12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME John R. Gerhab	14. MOTHER'S MAIDEN NAME Cressman		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	16. SOCIAL SECURITY NO. AWI	17. INFORMANT Babette Gerhab	Address #2
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Cerebral Vascular Accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ stating the underlying cause (c) _____			
INTERVAL BETWEEN ONSET AND DEATH 12 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (checkmark) attended the deceased from DEC. 26, 1966, to Jan. 12, 1967, that (I) (checkmark) last saw the deceased alive on Jan. 12, 1967, and that death occurred at M, from causes and on the date stated above.			
22a. SIGNATURE Richard I. Hochman, M.D.		8:35 AM ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 1/13/67
22c. PHYSICIAN'S NAME (Type) Richard I. Hochman, M.D.		22d. ADDRESS 59 Franklin St., Annapolis, Md.	
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial	23b. DATE THEREOF 1-14-1967	23c. NAME OF CEMETERY OR CREMATORIAL Hillside	23d. BURIAL LOCATION (City or Town) Philadelphia Pa. (County) (State)
24. FUNERAL DIRECTOR John M. Laylat Sons Annapolis, Md.	ADDRESS	25a. REC'D BY REGISTRAR JAN 16 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										CERTIFICATE OF DEATH		00099			
1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS					c. LENGTH OF STAY IN 1b NAVAL HOSPITAL										
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) NAVAL HOSPITAL					e. STREET ADDRESS 812 PARKWOOD AVENUE										
3. NAME OF DECEASED (Type or print) LAURA ARIENE GERRIOR					4. DATE OF DEATH Month Day Year JANUARY 6 1967										
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-27-1895		9. AGE (In years last birthday) yrs. 77		IF UNDER 1 YEAR Months Days Hours Min. 00 00 00 00					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME					10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE					11. BIRTHPLACE (County & State, or foreign country) Lynn, Mass.					
13. FATHER'S NAME JUDSON CONDON					14. MOTHER'S MAIDEN NAME Alice HAYNES					12. CITIZEN OF WHAT COUNTRY? U.S.A.					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. — — — 2					17. INFORMANT Address Vincent F. GERRIOR #2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 199.2 Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) _____ (c) _____										INTERVAL BETWEEN ONSET AND DEATH _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) NAVAL HOSPITAL, ANNAPOLIS, MD.		20f. (City or town) (County) (State) ANNAPOLIS, MD.						
21. I certify that (I) (this hospital) attended the deceased from 23 October, 1966 to 6 January, 1967 , that (I) (we) last saw the deceased alive on 6 January 1967 , and that death occurred at 9:50 A.M. , from the causes and on the date stated above.										22b. DATE SIGNED 1/27/67					
22a. SIGNATURE Wm. Lepson					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS NAVAL HOSPITAL, ANNAPOLIS, MD.										
22c. PHYSICIAN'S NAME (Type) LCDR WARD G. GYPSON, MC USN					23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					23b. DATE THEREOF 1-18-67		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS U.S. NAVAL ACADEMY, ANNAPOLIS		23d. LOCATION (City, town or county) (State) ANNAPOLIS, MD.	
24. FUNERAL DIRECTOR John M. Taylor, Annopolis, Md.					ADDRESS John M. Taylor, Annopolis, Md.					25a. REC'D BY REGISTRAR JAN 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00099

CERTIFICATE OF DEATH

00100

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician. Page 4 may be retained by the hospital or attending physician. If either, page 3 should be detached for use as the burial-transit permit. The please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY Anne Arundel MARYLAND		a. STATE Maryland Anne Arundel						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 316 West Street						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First Hervey	Middle Oliva	Last GILMORE	4. DATE OF DEATH January 8 1967	Month January	Doy 8	Year 1967
5. SEX		6. COLOR OR RACE	7. MARRIED	NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) 51 yrs.	IF UNDER 1 YEAR Months 5 Days 0 Hours 0 Min. 0	
Male		White	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	December 12, 1909	51		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Clerk		Retail Hardware		Canada		U.S.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
Patrick J. Gilmore		Georgienne Berard						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT		Address #2		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PERFORATED UTERUS PERITONITIS DUE TO 576X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ DUE TO _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH 2 days	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
MEDICAL CERTIFICATION		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DIABETES MELLITUS, HYPERTENSIVE heart DIS.						
		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) 		
21. I certify that (I) (this hospital) attended the deceased from JULY 1966 , to 8 JAN 1967 , that (I) (we) last saw the deceased alive on 8 JAN 1967 , and that death occurred at 11:00 P.M. M. from causes and on the date stated above.								
22. SIGNATURE Edward S. Beck		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1967				
23c. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City or Town) (County) (State) Annapolis, Md.		
24. FUNERAL DIRECTOR		ADDRESS John M. Taylor & Sons Annapolis, Md.		25a. REC'D BY REGISTRAR DATE JAN 12 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

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Bellis
Flowers
and plants
in the
botanical
garden

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00100

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00101

1. PLACE OF DEATH a. COUNTY <i>AA CO</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>AA CO</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Collier BCRNIE</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hillensville</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>D.O.A.-North-Anne Arundel-Hosp.</i>		d. STREET ADDRESS <i>372 E/1st Rd</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Joseph</i>		First <i>J</i>	Middle <i></i>	Last <i>90/1dys</i>	4. DATE OF DEATH Month <i>1</i> Doy <i>5</i> Year <i>1967</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <i>12-29-07</i>	9. AGE (In years last birthday) <i>59 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABORER</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MD.</i>	
13. FATHER'S NAME <i>JOHN GOLDYS SR.</i>		14. MOTHER'S MAIDEN NAME <i>MARY JANKOWSKI</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>YES</i>		16. SOCIAL SECURITY NO. <i>WW II</i>		17. INFORMANT Address <i>IDA WEGRYNIK</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>450.0</i> IMMEDIATE CAUSE (a) <i>Arteriosclerosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>Recent</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>last.</i>		(b) _____			
(c) _____		DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Baltimore</i>	(County) <i>MD</i> (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Spurlock</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>E. L. Wharff</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county) <i>Baltimore Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>1/9/67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Balto. Mort.</i>	23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR <i>J.L. Cornelly Son</i>	ADDRESS <i>300 Main</i>	25a. REC'D BY REGISTRAR <i>Charles J. Geiger</i>	25b. REGISTRAR'S SIGNATURE		
DATE JAN 10 1967					

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10100

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician director, page 3 should be detached for use as the burial-trust permit. Then please return to the hospital or attending physician or attending physician director, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00101

CERTIFICATE OF DEATH

00102

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pages 1 and 2 Annapolis		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		d. STREET ADDRESS 19 Hill Street							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Emily		First	Middle	Last	4. DATE OF DEATH GRANT January	Month	Doy Year 18 1967						
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 21, 1891	9. AGE (In years lost birthday) 75 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. DAYS Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk			10b. KIND OF BUSINESS OR INDUSTRY Printing		11. BIRTHPLACE (County & State, or foreign country) Annapolis Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.						
13. FATHER'S NAME William H. Taylor				14. MOTHER'S MAIDEN NAME Matilda Thomas									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 216-44-552A		17. INFORMANT Son - Clarence H. Grant same as #2 above								
Address													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERAL HEMORRHAGE, MIDDLE CER. ART. INTERVAL BETWEEN ONSET AND DEATH 3 days													
DUE TO 331X													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ATHEROSCLEROSIS													
DUE TO													
(c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
19													
21. I certify that (I) (this hospital) attended the deceased from 1965 , to 1967 , that (I) (we) last saw the deceased alive on 18-1-67 , 1967, and that death occurred at 9:35 P.M. M. from causes and on the date stated above.													
22a. SIGNATURE Edward S. Beck								22b. DATE SIGNED 1-19-67					
22c. PHYSICIAN'S NAME (Type) Edward S. Beck				22d. ADDRESS Franklin St.,									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/23/67		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Naval Academy Cemetery		23d. LOCATION (City or Town) Annapolis		(County) A.A.		(State) Md.			
24. FUNERAL DIRECTOR Beverley E. Hopping		ADDRESS Beverley E. Hopping		25a. REC'D BY REGISTRAR DATE JAN 23 1967		25b. REGISTRAR'S SIGNATURE Charles Judge							
Hopping Funeral Home - Annapolis, Md.													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00102

CERTIFICATE OF DEATH

00103

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT GEORGE G. MEADE		c. LENGTH OF STAY IN b 59 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HELEN		First P.	Middle GRAY
4. DATE OF DEATH JANUARY 20	Month 1967	Dey 1967	Year
5. SEX FEMALE	6. COLOR OR RACE NEGROID	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 OCT 1925
9. AGE (In years last birthday) 41 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0	12. IF UNDER 24 HRS. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Prince George, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Zack Todd		14. MOTHER'S MAIDEN NAME Hester Tucker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or grade or service) No		16. SOCIAL SECURITY NO. 229-16-5780	
17. INFORMANT Theodore Gray (husband)		Address 5703 Gist Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED METASTATIC CARCINOMA		INTERVAL BETWEEN ONSET AND DEATH 6 MO.	
19.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from..... saw the deceased alive on.....		23. No.v....., 19....., to.....Jan....., 19....., that <input checked="" type="checkbox"/> (we) last died....., 19....., and that death occurred at....., from the causes and on the date stated above.	
22e. SIGNATURE <i>Jorge J. Ramirez</i>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 20 Jan 67
22c. PHYSICIAN'S NAME (Type) JORGE J. RAMIREZ, CPT, MC		22d. ADDRESS KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) B	23b. DATE THEREOF 1/25/67	23c. NAME OF CEMETERY OR CREMATORIUM National Cemetery	23d. LOCATION (City, town or county) Baltimore, MD
24. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph L. Peas</i>		ADDRESS 2222 N. Franklin Baltimore, MD	25a. REC'D BY REGISTRAR DATE JAN 23 1967
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**10 TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to a burial, cremation, or removal, and in any event, within 72 hours after death.

00103

CERTIFICATE OF DEATH

00104

1. PLACE OF DEATH o. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 4 days	b. COUNTY <i>Anne Arundel</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS Box 28-A Rt 3					
3. NAME OF DECEASED (Type or print) #34244 Elmer		First Green	Middle Lost				
4. DATE OF DEATH 1 10 1967	Month 1	Doy 10	Year 1967				
S. SEX Male	6. COLOR OR RACE Negro	7. MARRIED WIDOWED <input type="checkbox"/> Sep DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/2/02				
9. AGE (In years last birthday) 64 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. DAYS 0	12. IF UNDER 24 HRS. Hours 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver	10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (County & State, or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Edward Green		14. MOTHER'S MAIDEN NAME Mary Ann Benedict					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT <i>Elmer Green Hospital Records</i>	Address <i>Edgewood Rd Anna</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Liver DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 1561 (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Psychotic Depressive Reaction			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. - 14		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) -----	(County) -----	(State) -----	
21. I certify that (I) (this hospital) attended the deceased from 1/6/1967 , to 1/10/1967 , that (I) (we) last saw the deceased alive on 1/10/1967 , and that death occurred at 4:25 M, from causes and on the date stated above.							
22a. SIGNATURE <i>Elmer Green</i>		M.D. L. Benedict, M.D.	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 1/10/67	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.		22d. ADDRESS Crownsville State Hospital, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/14/67	23c. NAME OF CEMETERY OR CREMATORIAL John Wesley		23d. LOCATION (City or Town) Annapolis	(County) Anne Arundel	(State) Md.
24. FUNERAL DIRECTOR <i>William Reese Jr</i>		ADDRESS 108 W Wash St.		25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge		
VR A15 (4) 20 M 1/66		DATE JAN 11 1967					

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00104

CERTIFICATE OF DEATH

00105

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY A. A. Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY A. A. Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DAVIDSONVILLE 221			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) A. A. GENERAL Hosp.				d. STREET ADDRESS Wayson Road			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) MARGARET PATTERSON		First M	Middle G	Last RENE	4. DATE OF DEATH	Month 15	Year 1967
S. SEX F.	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-15-1912	9. AGE (In years 55 last birthday) 55 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY St. of MD.		11. BIRTHPLACE (County & State, or foreign country) ANNAPOLIS, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William B. Patterson		14. MOTHER'S MAIDEN NAME Mihie M. Monahan					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? NO		16. SOCIAL SECURITY NO. —		17. INFORMANT WM H. GREENE #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease INTERVAL BETWEEN ONSET AND DEATH 8 years							
443X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) {							
DUE TO (c) }							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Severna Park (County) Maryland (State) —	
21. I certify that (I) (this hospital) attended the deceased from 1959 , to Jan 1967 , that (I) (we) last saw the deceased alive on Jan 10 1967 , and that death occurred at 9A M, from causes and on the date stated above.							
22a. SIGNATURE Francis I. Codd		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 1-16-67
22c. PHYSICIAN'S NAME (Type) Francis I. Codd M.D.				22d. ADDRESS Severna Park, Maryland			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-18-67		23c. NAME OF CEMETERY OR CREMATORIAL ST. MARYS		23d. LOCATION (City or Town) Annapolis (County) A.H. MD. (State) —	
24. FUNERAL DIRECTOR John M. Leyport & Sons		ADDRESS Annapolis, Md.		25a. REC'D BY REGISTRAR MAN 18 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00105

CERTIFICATE OF DEATH

00106

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician. Then please remove carbon papers. Pages and 2 director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY ANNE ARUNDEL			
RURAL - GLEN BURNIE		10 DAYS		RURAL - GLEN BURNIE					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NORTH ARUNDEL HOSPITAL				d. STREET ADDRESS 97 ELM AVE GARLAND PARK					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First JOHN	Middle	Last GREENWALD	DATE OF DEATH JANUARY 19 1967	Month	Day	Year	
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 8 1891	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) APT. SUPT.			10b. KIND OF BUSINESS OR INDUSTRY MAINTENANCE			11. BIRTHPLACE (County & State, or foreign country) AUSTRIA			
13. FATHER'S NAME Anthony Greenwald				14. MOTHER'S MAIDEN NAME Rosina Regget					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 056/10/4298		17. INFORMANT Mrs. Helene A. Greenwald			Address Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Congestive Heart failure lost. (b) DUE TO (c) DUE TO Thrombosis right auricle								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 11/19/67		(County) Baltimore	(State) Md.
21. I certify that I (this hospital) attended the deceased from 11/18/67 , to 11/19/67 , 19, that I (we) last saw the deceased alive on 11/18/67 , and that death occurred at 11/19/67 M, from causes and on the date stated above.									
22a. SIGNATURE J. B. RAMIREZ		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/19/67	
22c. PHYSICIAN'S NAME (Type) J. B. RAMIREZ		22d. ADDRESS 1672 North Burnie Rd Baltimore MD 21212		23d. LOCATION (City or Town) Glen Burnie, Md.		(County) Md.		(State) Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 23, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Glen Haven Cemetery		23d. LOCATION (City or Town) Glen Burnie, Md.			
24. FUNERAL DIRECTOR R.V. SINGLETON		ADDRESS GLEN BURNIE, MD.		25a. REC'D BY REGISTRAR JAN 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00106

CERTIFICATE OF DEATH

00107

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD # 7 Pasadena		d. STREET ADDRESS Treetop Farm	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Mary	Middle C.	Last Groom	4. DATE OF DEATH 1 6-28-79	Month 1	Day 2	Year 1967
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-28-79	9. AGE (In years last birthday) 87 yrs.	10. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State, or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Wilbert Wilson		14. MOTHER'S MAIDEN NAME Christine Sellers					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Family Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis 153.0 Ccnditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) intestinal obstruction (c) Carcinoma of ascending colon							
INTERVAL BETWEEN ONSET AND DEATH Days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-19 - 1966 , to 1 - 2, 1967 , that (II) (we) last saw the deceased alive on 1-1 1966 , and that death occurred at 11:00 A.M. from the causes and on the date stated above.		22b. DATE SIGNED 1-2-67					
22a. SIGNATURE E. A. Tolentino		22b. DATE SIGNED 1-2-67					
22c. PHYSICIAN'S NAME (Type) E. A. Tolentino, M.D.		22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 5, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Parkwood Cemetery		23d. LOCATION (City, town or county) (State) Parkville, Maryland	
24. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland		ADDRESS		25a. REC'D BY REGISTRAR JAN 9 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	
VR A15 (4) 20M 1/65							

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00107

CERTIFICATE OF DEATH

00108

1. PLACE OF DEATH a. COUNTY <i>a. A.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>a. a.</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Circumapolis</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Galesville</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>a. a. General</i>		d. STREET ADDRESS <i>221</i>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>Webster</i>		First <i>Male</i>	Middle <i>Col.</i>			
4. DATE OF DEATH <i>7 Jan 1967</i>		Month <i>Jan</i>	Doy Year <i>7 1967</i>			
S. SEX <i>Male</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED WIDOWED <input type="checkbox"/> <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/> <input type="checkbox"/>			
8. DATE OF BIRTH <i>7-1-1894</i>	9. AGE (In years last birthday) yrs. <i>72</i>	10. IF UNDER 1 YEAR Months <i>7</i>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>MC</i>				
11. BIRTHPLACE (County & State, or foreign country) <i>MC</i>		12. CITIZEN OF WHAT COUNTRY? <i>A.S.A.</i>				
13. FATHER'S NAME <i>Elie Gross</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Reed</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-07-3388</i>				
17. INFORMANT <i>William Jackson</i>		Address <i>Galesville</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Myocardial infarction</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i>				
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) <i>Hypertensive cardiovascular disease</i>		Year <i>Year</i>				
DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>Jan 1967</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>9</i>	20f. (City or town) <i>Jan. 7, 1967</i>	(County) <i>63</i>	(State) <i>MD</i>
21. I certify that (I) (this hospital) attended the deceased from <i>Jan</i> , 19 <i>63</i> , to <i>Jan. 7, 1967</i> , thot (I) (we) lost saw the deceased alive an <i>Dec. 7, 1966</i> , and that death occurred at <i>3 P.M.</i> from causes and on the date stated above.						
22a. SIGNATURE <i>William F. Smith</i>		22b. DATE SIGNED <i>1/8/67</i>				
22c. PHYSICIAN'S NAME (Type) <i>William Rease #</i>		22d. ADDRESS <i>Circle M</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1-12-1967</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Chesapeake Memorial Cemetery</i>	23d. LOCATION (City or Town) <i>Consenville</i> (County) <i>MD</i> (State)		
24. FUNERAL DIRECTOR: <i>William Rease #</i>		ADDRESS <i>Circle M</i>		25a. REC'D BY REGISTRAR <i>10</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

80100

20100

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00108

CERTIFICATE OF DEATH

00109

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN lb 4 Days d	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XXXXX XXXXXXXXX XXXX Glen Burnie 021	
3. NAME OF DECEASED First John Middle (nni) Last Hammons		4. DATE OF DEATH Jan 1 Month Day Year Jan 1 1 67	
5. SEX Male 6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH 9 - 20 1900		9. AGE (In years last birthday) 66 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer		10b. KIND OF BUSINESS OR INDUSTRY Laborer	
11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Pete Harjmoris		14. MOTHER'S MAIDEN NAME Emily Fowler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 232-221938-A	
17. INFORMANT Mrs. Jean Miller (Daughter) Same as #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Emphysema</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 weeks</i>	
5271 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>ASHD</i> (c) <i>? Pneumonia</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 8</u> , 1966, to <u>Jan 1</u> , 1967, that (I) (we) last saw the deceased alive on <u>Jan 1</u> , 1967, and that death occurred at <u>95</u> M, from causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE <i>Robert J. Abolins</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) ROBERT J. ABOLENS, M.D.		22d. ADDRESS <i>400 Gandy Hwy N Glen Burnie, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 5, 1967	
23c. NAME OF CEMETERY OR CEMETORY Haven Mem. Park		23d. LOCATION (City or Town) (County) (State) Glen Burnie, Md.	
24. FUNERAL DIRECTOR R.V. Singleton		ADDRESS Glen Burnie, Md.	
25a. REC'D BY REGISTRAR JOAN H. JOHNSON		25b. REGISTRAR'S SIGNATURE <i>Joan H. Johnson</i>	

20100

HIGH TO STANDARD

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2 1 M
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00109 00110

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 5 wks.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ELLA	Middle J.	Last HARRIS
4. DATE OF DEATH Jan. 8 1967	Month Jan.	Day 8	Year 1967
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2 June 1887
9. AGE (In years last birthday) 79 yrs.	10. IF UNDER 1 YEAR Months 79	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Lake City - Tenn.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME (unknown)	14. MOTHER'S MAIDEN NAME (unknown)		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 212-40-8166	17. INFORMANT T(William J. Bratcher - Same as # 2	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 450.0 <i>Bronchial pneumonia</i>			
DUE TO (b) <i>Arterio losclerosis</i>			
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Fracture hip R</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>fall at home</i>		
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Linhardt</i> EXAMINER'S NAME (Type) ROBERT P. WISE ELMER G. LINHARDT, Annapolis, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	22. DATE SIGNED 1/18/67
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/11/67	23c. NAME OF CEMETERY OR CREMATORIAL Glen Haven Memorial Pk.	23d. LOCATION (City, town or county) (State) Glen Burnie, Maryland
24. FUNERAL DIRECTOR Singleton Funeral Home/Glen Burnie, Maryland	ADDRESS	25a. REC'D BY REGISTRAR JAN 11 1967	REGISTRAR'S SIGNATURE <i>Charles Judge</i>

01100

MANUFACTURED BY THE AMERICAN STAINLESS STEEL CORPORATION
STAINLESS STEEL

01100

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00110

00111

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 12 hrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 9 Poplar Ave.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Douglas	Middle Lawrence	Last HAWKINS, Jr.
4. DATE OF DEATH Month January	Month 14	Doy 1967	Year
S. SEX Male	6. COLOR OR RACE Negro	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>
8. DATE OF BIRTH Jan. 14, 1967	9. AGE (In years lost birthday) yrs. 0	IF UNDER 1 YEAR Months 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Anne Arundel, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Douglas Lawrence Hawkins Sr.	14. MOTHER'S MAIDEN NAME Mary Catherine Ross		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Hospital records.	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7735 <i>Respiratory failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Imaturity (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 12 hr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) SouthRivMedCent., Edgewater, Md.
20f. (City or town) (County) (State)			
21. I certify that (I) Antonio M. Rivera attended the deceased from Jan. 14, 1967 , to Jan. 14, 1967 , that (I) Antonio M. Rivera last saw the deceased alive on Jan. 14, 1967 , and that death occurred at Arnold, Md. from causes and on the date stated above.			
22a. SIGNATURE Antonio M. Rivera		22b. DATE SIGNED 11:45 PM 17 Jan 67	
22c. PHYSICIAN'S NAME (Type) Antonio M. Rivera, M.D.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/16/67	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mt. Calvary		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR C.E. Hicks, III		25a. REC'D BY REGISTRAR A.A. Co	
ADDRESS Frederick, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE JAN 20 1967			

11100

01100

Labour Party

Socialist

Labour Party

Communist

PCI

Communist

Workers Party

Fraternal Federation Labour Party

Red Army

Communist Party

Communist Party

CPA

CPA

CPA

Workers Party

CPA

Communist Party

Communist Party

Communist Party

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Communist Party

CPA - CPD

Communist Party

Communist Party

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb D.O.A.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) (Dead on arrival) Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Winifred		First W	Middle E	
3. SEX Female		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 3-7-1893	
6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 73 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (County & State, or foreign country) Mt. Harmony, Maryland	
13. FATHER'S NAME WILLIAM WELLS		14. MOTHER'S MAIDEN NAME AGNES LANE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	17. INFORMANT MR. CHAS. D. HEARD #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO 33IX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH unknown		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Franklin St., Annapolis, Md.	20f. (City or town) (County) (State)
21. I certify that (I) attended the deceased from 2/19 , 19 62 , to 12/13 , 19 66 that (I) saw the deceased alive on 12/13 , 19 66 , and that death occurred at M , from causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
22a. SIGNATURE Richard I. Hochman		M.D. ATTENDING PHYS. Richard I. Hochman, M.D.	22b. DATE SIGNED 8:20 PM 1/5/67	
22c. PHYSICIAN'S NAME (Type) Richard I. Hochman, M.D.		22d. ADDRESS 59 Franklin St., Annapolis, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-7-1967	23c. NAME OF CEMETERY OR CREMATORIAL HILLCREST CEM.	
24. FUNERAL DIRECTOR JOHN M. TAYLOR & SONS ANNAPOULIS MD.		ADDRESS	25a. REC'D BY REGISTRAR Charles Judge	
		DATE JAN 10 1967	25b. REGISTRAR'S SIGNATURE	

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Foreign exchange

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5. *Leucosia* *leucostoma* *leucostoma*

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 3 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00112

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00113

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 3836 Sixth St.				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Maryland House of Correction				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) HARRY		First W.	Middle HINKLE, Jr.	Lost	4. DATE OF DEATH January 17 1967	Month January	Doy 17	Year 1967		
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	B. DATE OF BIRTH Aug. 12, 1923	9. AGE (In years last birthday) 43 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. DAYS 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY Security		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.				
13. FATHER'S NAME Harry W. Hinkle				14. MOTHER'S MAIDEN NAME Nora Bennaman						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Nora Hinkle - 3836 Sixth St., Baltimore		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Arteriosclerotic Heart Disease.						INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) (c)		DUE TO DUE TO DUE TO								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Ritchie Hwy., A.A.C.O., Md.		(County) A.A.C.O.		(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>Charles S. Petty</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 1/18/67				
EXAMINER'S NAME (Type) Charles S. Petty				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>						
				OEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
				Address (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-21-1967		23c. NAME OF CEMETERY OR CREMATORIAL Glen Haven Memorial Pk.		23d. LOCATION (City or Town) Ritchie Hwy., A.A.C.O., Md.		(County) A.A.C.O.		(State) Md.
24. FUNERAL DIRECTOR George J. Gonce-4001 Ritchie Hwy., Baltimore		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

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21100

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

00113

CERTIFICATE OF DEATH

00114

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL, GLEN BURNIE		c. LENGTH OF STAY IN lb 58 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL- MILLERSVILLE 02-1							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NORTH ARUNDEL HOSPITAL				d. STREET ADDRESS RT.2 BOX 174							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First GOODIN	Middle EDWARD	Last HINSON	4. DATE OF DEATH	Month JANUARY	Day 4	Year 19 67			
S. SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.			
MALE	WHITE	WIDOWED <input checked="" type="checkbox"/>			MARCH 16, 1889	77 yrs.	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR-RETIRED			10b. KIND OF BUSINESS OR INDUSTRY DRYCLEANING			11. BIRTHPLACE (County & State, or foreign country) ALBERNARLE, NOTRH CAROLINA USA			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Frank Hinson				14. MOTHER'S MAIDEN NAME Shara (unknown)							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO one				16. SOCIAL SECURITY NO. 214-01-1683				17. INFORMANT VIRGINIA GRIFFIN RT 2 BOX 174 MILLERSVILLE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>334X</i>				<i>Cerebral Arteriosclerosis</i>				INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				<i>Arteriosclerosis general</i>							
DUE TO (b)											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Nov</i> , 1966, to <i>Jan 4</i> , 1967, that (I) (we) last saw the deceased alive on <i>Jan 3</i> , 1966, and that death occurred at <i>2:15 P.M.</i> from causes and on the date stated above.				22b. DATE SIGNED <i>Jan 4, 1967</i>							
22a. SIGNATURE <i>Joseph Taler</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
22c. PHYSICIAN'S NAME (Type) JOSEPH TALER				22d. ADDRESS <i>95 Aquahart Rd. Glen Burnie, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Jan. 7, 1967</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Carolina Memorial Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Concord N. Carolina</i>					
24. FUNERAL DIRECTOR R.V. Singleton		ADDRESS <i>Glen Burnie, Md.</i>		25a. REC'D BY REGISTRAR <i>JAN 9 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00114

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00115

1. PLACE OF DEATH a. COUNTY		Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie-rural		c. LENGTH OF STAY IN lb 25 yrs.		b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		d. STREET ADDRESS Rt. 10 Box 106 Lake Shore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena -rural	
3. NAME OF DECEASED (Type or print)		First Bernard	Middle J.	Last Holmes	4. DATE OF DEATH 1 17 1967
S. SEX male	6. COLOR OR RACE white	7. MARRIED WIDOWED	NEVER MARRIED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 5/29/1908
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance		10b. KIND OF BUSINESS OR INDUSTRY Insurance		9. AGE (In years lost birthday) 99 58 yrs.	
13. FATHER'S NAME Thomas Joseph Holmes Sr.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 213-28-5676		17. INFORMANT Margaret Holmes (Wife) As Above	
Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Steering wheel injury of chest with transection</u> DUETO of aorta Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) driver in auto-fixed object collision			
20c. TIME OF INJURY Month, Day, Year Hour a.m. ? p.m. 1 17 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street	20f. (City or town) Glen Burnie	(County) (State) A.A. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Werner U. Spitz</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)			
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		22. DATE SIGNED 1/17/67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/20/1967	23c. NAME OF CEMETERY OR CREMATORIAL Glen Haven Mem. Park	23d. LOCATION (City or Town) Glen Burnie, Md.	(County) (State)
24. FUNERAL DIRECTOR Raymond C. Fink		ADDRESS Glen Burnie, Md.		25a. RECD BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE
				DATE JAN 19 1967	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 2 Film G505 1/30/67 mh

00115

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Annapolis Nursing Home</i>			
3. NAME OF DECEASED (Type or print)		First <i>Nettie</i>	Middle <i>M.</i>
4. DATE OF DEATH Month <i>JAN</i>		Year <i>21</i>	5. DATE OF DEATH Month <i>JAN</i>

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
a. STATE <i>Maryland</i>	
b. COUNTY <i>Anne Arundel</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md</i>	
d. STREET ADDRESS <i>1202 Sterling Drive</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

S. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>JUNE 17, 1880</i>	9. AGE (In years last birthday) <i>86 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. Doy <i>19</i>	13. Year <i>67</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>JAMES MANDERS</i>		14. MOTHER'S MAIDEN NAME <i>EMMA SOMMERS</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <i>210-16-738047</i>			17. INFORMANT Address <i>VAN BUREN ANNAPOLIS NURSING Bay Ridge</i>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Dehydration; Infected Decubiti;</i> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (last) (b) <i>Severe A.S.O.V.D.; chronic brain syndrome</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Recent left hip fracture. Degenerative osteoarthritis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>Hip fracture was spontaneous.</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Hip fracture was spontaneous.</i>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Annapolis Nursing Home</i>	20f. (City or town) <i>Annapolis</i>	(County) <i>Anne Arundel</i>	(State) <i>Md.</i>

21. I certify that (I) (this hospital) attended the deceased from <i>April</i> , 19 <i>66</i> , to <i>Jan 20</i> , 19 <i>67</i> that (I) (we) last saw the deceased alive on <i>Jan 20</i> , 19 <i>67</i> , and that death occurred at <i>9 P.M.</i> from causes and on the date stated above.		22b. DATE SIGNED <i>1-21-1967</i>
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22a. SIGNATURE <i>Peter F. Verkouw</i>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>1-21-1967</i>
22c. PHYSICIAN'S NAME (Type) <i>PETER F. VERKOUW, MD</i>	22d. ADDRESS <i>1407 FOREST DRIVE ANNAPOLIS, MD</i>			

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>1/25/67</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>OXFORD CEMT.</i>	23d. LOCATION (City or Town) (County) (State) <i>Oxford MD.</i>
24. FUNERAL DIRECTOR <i>John M. Lafferty Annapolis MD</i>	25a. REC'D. BY REGISTRAR DATE JAN 24 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00117

00116

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE		c. LENGTH OF STAY IN 1b		e. STATE MARYLAND					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NORTH ARUNDEL GENERAL		f. COUNTY Anne Arundel							
e. NAME OF DECEASED (Type or print)		First SAMUEL	Middle ELIAH	Last HOWARD	4. DATE OF DEATH JAN 24 1967	Month JAN	Dey 24	Year 1967	a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX M		6. COLOR OR RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 20 1924	9. AGE (In years last birthday) 43 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.		
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) ARUNDEL Co Md.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME SAMUEL E HOWARD Sr.		14. MOTHER'S MAIDEN NAME ANNIE BLAND							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give rank and date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT HILDA HOWARD		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH SUDDEN							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		MASSIVE CEREBRAL HEMORRHAGE							
445X Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) MALIGNANT HYPERTENSION							
DUE TO (c)		3 YRS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 1964	(County)	(State)		
21. I certify that (I) (This hospital) attended the deceased from.....		1964	19....., to.....	1967	19....., that (I) (we) last saw the deceased alive on JAN 17 1967, and that death occurred at 2:30 A.M. from the causes and on the date stated above.				
22a. SIGNATURE Arthur Lankford Jr.		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 1-24-67			
22c. PHYSICIAN'S NAME (Type) ARTHUR LANKFORD, JR., M.D.		22d. ADDRESS 1934 Mountain Rd Pasadena, Md. 21122							
23e. BURIAL, CREMATION OR REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-28-1967	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mount CALVARY	23d. LOCATION (City, town or county) ARUNDEL Co Md.			(State)		
24. FUNERAL DIRECTOR'S SIGNATURE I.L Brown & Son		ADDRESS 123 W. MONTGOMERY St		25a. REC'D BY REGISTRAR DATE JAN 27 1967	25b. REGISTRAR'S SIGNATURE Charles Judge				

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1and2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00117

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00118

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> ND <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel General			d. STREET ADDRESS 102 E. Fort Ave.		30.4
3. NAME OF DECEASED (Type or print) First Jordan Middle Hutto			4. DATE OF DEATH Month 1 Day 8 Year 1967		
S. SEX male	6. COLOR OR RACE white	7. MARRIED WIDDOWED	8. DATE OF BIRTH 12/1/1905	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Don Worker		10b. KIND OF BUSINESS DR INDUSTRY	11. BIRTHPLACE (State or foreign country) Brandall Texas		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. yes World War II 457-18-5943	17. INFORMANT Address Mrs. Edna Hutto (-above)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning P234 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) stating the underlying cause lost. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Driver of auto which ran off roadway into shallow water			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 3:00 PM 1 8 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) water	20f. (City or town) Annapolis	(County) (State) A.A. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Werner U. Spitz M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/12/67	23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National Cem.	23d. LOCATION (City or Town) 5501 Frederick Rd.	(County) (State)
24. FUNERAL DIRECTOR John J. Conner & Son, Inc., Stollings		ADDRESS 90	25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE
			DATE JAN 10 1967		

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00118

CERTIFICATE OF DEATH

00119

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE b. COUNTY	
Anne Arundel MARYLAND		Maryland Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Glen Burnie, --		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
North Arundel Hospital		Millersville	
d. STREET ADDRESS			
3. NAME OF DECEASED First Middle Last		4. DATE OF DEATH Month Day Year	
(Type or print) David C. Ingraham		Jan. 13 1967	
5. SEX		6. COLOR OR RACE	
Male White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
None		None	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
David L. Ingraham		Joyce M. Feeney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
no None		17. INFORMANT	
		Address	
Mr. David Lee Ingraham (Father) Same as 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 525X INTERSTITIAL PNEUMONITIS INTERVAL BETWEEN ONSET AND DEATH SEVERAL HOURS			
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c)			
DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	
p.m.		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)	
		(State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 10, 1966, to Jan 13, 1967, that (I) (we) last saw the deceased alive on Jan 10, 1967, and that death occurred at 8:55 AM, from the causes and on the date stated above.			
22a. SIGNATURE Alvin W. Hecker		22b. DATE SIGNED Jan 13 1967	
22c. PHYSICIAN'S NAME (Type) ALVIN W. HECKER		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> JAN 13 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 13, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL Meadowridge Mem. Park		23d. LOCATION (City, town or county) Howard Co. Md. (State)	
24. FUNERAL DIRECTOR Robert Pearce		ADDRESS	
Singleton Funeral Home		25a. REC'D BY REGISTRAR JAN 18 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

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ANSWER Keys and Solutions

Antigone (Sophocles) 1970

• • • **DECEMBER**

新嘉坡文華大酒店

INTERIM REPORT

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ALVIN M HESKETT

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00119

CERTIFICATE OF DEATH

00120

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 35 min.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) (Expired in Emergency Room) Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Amy		First Woodruff	Middle JANSSENS
4. DATE OF DEATH Month January	Day 26	Year 1967	5. SEX Female
6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 20, 1894	9. AGE (In years lost birthday) 72 yrs.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY	10b. KIND OF BUSINESS OR INDUSTRY STEEL CO	11. BIRTHPLACE (County & State, or foreign country) BANTO, Md.	12. CITIZEN OF WHAT COUNTRY USA
13. FATHER'S NAME — WOODRUFF	14. MOTHER'S MAIDEN NAME IDA WESCO		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 108-00-0000	17. INFORMANT Jos. JANSSENS - Above	Address Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Congestive heart failure INTERVAL BETWEEN ONSET AND DEATH 1 hour			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO atherosclerosis (c) —			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
20f. (City or town) (County) (State)			
21. I certify that (I) Richard I. Hochman attended the deceased from 9 , 19 66 , to 1/20 , 19 67 that (I) did not last saw the deceased alive on 1/9 19 67 and that death occurred at — M, from causes and on the date stated above.			
22a. SIGNATURE Richard I. Hochman		ATTENDING PHYS. XX MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 8:25 PM, 1/27/67
22c. PHYSICIAN'S NAME (Type) Richard I. Hochman, M.D.		22d. ADDRESS 59 Franklin St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-30-67	23c. NAME OF CEMETERY OR CREMATORIAL MEADOWRIDGE
23d. LOCATION (City or Town) (County) (State) Dorsey Howard Md.		23e. REC'D BY REGISTRAR DATE JAN 31 1967	
24. FUNERAL DIRECTOR Robert S. Lanigan, severna Ph. h.		ADDRESS ROBERT S. LANNIGAN	25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00120

CERTIFICATE OF DEATH

00121

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>A. A. Co.</i>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD.</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St. MARGARET'S</i>			c. LENGTH OF STAY IN lb		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>BAY MANOR Nursing HOME</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>SARAH AKAYASARA</i> First <i>SARAH</i> Middle <i>EVA</i> Last <i>JARRELL</i>			4. DATE OF DEATH / 1 / 28 / 67		
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-24-1882</i>	9. AGE (In years last birthday) <i>87</i> yrs.	10. IF UNDER 1 YEAR Months <i>0</i> Dofs <i>0</i> Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOME</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>		
11. BIRTHPLACE (County & State, or foreign country) <i>HENDERSON MD.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		
13. FATHER'S NAME <i>William Pritchett</i>			14. MOTHER'S MAIDEN NAME <i>SARAH SPENCE</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>Address ALEX JARRELL #2</i>		
17. INFORMANT <i>ALEX JARRELL</i>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>493X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Arteriosclerosis</i> DUE TO lost. (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>Arteriosclerosis, generalized, coronary heart disease</i>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fracture of skull</i>			
20c. TIME OF INJURY Month, Doy, Year Hour o.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>FRANKLIN ST.</i> (County) <i>Annapolis, MD.</i> (State) <i>M.D.</i>
21. I certify that (I) (this hospital) attended the deceased from <i>1/22</i> , 1967, to <i>1/28</i> , 1967, that (I) (we) last saw the deceased alive on <i>1/26</i> , 1967, and that death occurred at <i>6:30 P.M.</i> from causes and on the date stated above.					
22a. SIGNATURE <i>R. I. Hochman</i>			22b. DATE SIGNED <i>1-30-67</i>		
22c. PHYSICIAN'S NAME (Type) <i>R. I. Hochman</i>			22d. ADDRESS <i>FRANKLIN ST. Annapolis, MD.</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>1-31-67</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>GREENSBORO, MD.</i>		23d. LOCATION (City or Town) <i>GREENSBORO</i> (County) <i>MD.</i> (State) <i>MD.</i>
24. FUNERAL DIRECTOR <i>John M. Taylor & Sons Annapolis, MD.</i>			25a. REC'D BY REGISTRAR DATE <i>CHARLES JUDGE FEB 1 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

02100

02100

02100

FOR STATE
HEALTH DEPT.

00121

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00122

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Maryland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel General Hospital		d. STREET ADDRESS Box 46A Holliday Mobile Estates	
3. NAME OF DECEASED (Type or print) CLARENCE		First W.	Middle JOHNSON
Last Sr.		4. DATE OF DEATH 1 10 1967	Month Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gas Station Operator		10b. KIND OF BUSINESS OR INDUSTRY Self-Empl.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Norman L. Johnson		14. MOTHER'S MAIDEN NAME Anna V. Davis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No		16. SOCIAL SECURITY NO. 217/14/6134	
17. INFORMANT Mrs Eleanor G. Johnson		Address Same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease			
422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Exertion during scuffle and apparent neck injury			
19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Died about 15 minutes after scuffle	
20c. TIME OF INJURY Month, Day, Year 6-8:30 p.m. 1 10 1967		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home & Street
20f. (City or town) Glen Burnie		(County) A.A.	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Rudiger Breitenecker</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Rudiger Breitenecker, M.D.		22. DATE SIGNED 1/11/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 14, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Glen Haven Mem'l Park
23d. LOCATION (City or Town) Glen Burnie,		(County) Md.	(State)
24. FUNERAL DIRECTOR R.V. SINGLETON		ADDRESS GLEN BURNIE, MD.	25a. REC'D BY REGISTRAR DATE JAN 13 1967
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

• \$100

25100

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00122

00123

1. PLACE OF DEATH

e. COUNTY

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Annapolis

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

23 Wilson Road

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

26 1967

5. SEX

Male

6. COLOR OR RACE

Col.

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

7-4-1891

9. AGE (In years
last birthday)

75

yrs.

10. IF UNDER 1 YEAR

Months

Deys

11. IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10b. KIND OF BUSINESS OR INDUSTRY

Md.

11. BIRTHPLACE (County & State, or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles H Johnson

14. MOTHER'S MAIDEN NAME

Samie Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes give rank and dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

215-09-0883 Rebecca Johnson Anna. M.D.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Arteriosclerotic Hypertensive Cardio Vascular

INTERVAL BETWEEN
ONSET AND DEATH

1½ years

443X

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

Disease

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY
PERFORMED?YES NO

20a. ACCIDENT WAS UNDERLYING

OR CONTRIBUTING

CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County) (State)

Hour a.m.

p.m.

While at work

Not While at work

19

21. I certify that (I) (this hospital) attended the deceased from July 1965 to Jan. 26, 1967 that (I) (we) last

saw the deceased alive on Jan. 26, 1967, and that death occurred at p.m., from the causes and on the date stated above.

22e. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

R. L. Richardson, M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED

1-28-67

22d. ADDRESS

110 Clay St., Annapolis, Md., 21401

23a. BURIAL, CREMATION, REMOVAL
(Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORI

23d. LOCATION (City, town or county) (State)

Burial 1-30-1967

Fowlers

Best Gate Md.

24 FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE JAN 30 1967 Charles Judge

William Reesett. Anna M.D.

82162

82162

A 200

standard equipment required
and must prove its value

group of instruments and apparatus required

to do the work

X

IGMS - M. file gamma counts off

Coabsorbent

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00123

CERTIFICATE OF DEATH

00124

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to a burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i>		b. COUNTY		
b. CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>		c. LENGTH OF STAY IN lb		c. CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		30.4		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>North Arundel Hospital</i>				d. STREET ADDRESS <i>5629 Anthony Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <i>Raymond</i>	Middle <i>L.</i>	Last <i>Jones</i>	4. DATE OF DEATH Jan. 5, 1967	Month Jan.	Day 5,	Year 1967
S. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>9-9-1900</i>	9. AGE (In years at birthday) <i>66</i>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Martin Company</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Charles B. Jones</i>				14. MOTHER'S MAIDEN NAME <i>Anna Raborg</i>		Address <i>Glen Burnie</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>yes WW</i>		16. SOCIAL SECURITY NO. <i>2740141444</i>		17. INFORMANT <i>Mrs Anne Bailey</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>arteriosclerotic Heart Disease</i> DUE TO <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>coronary atherosclerosis</i> (b) <i>coronary atherosclerosis</i> DUE TO (c) <i>Diabetes mellitus - 15 years</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes mellitus - 15 years</i>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <i>No</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>1950</i> , 19, to <i>1967</i> , 19, that (I) (we) last saw the deceased alive on <i>1967</i> , 19, and that death occurred at <i>A</i> M, from causes and on the date stated above.								
22a. SIGNATURE <i>Stuart D. Sunday MD</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) <i>STUART D. SUNDAY</i>		22d. ADDRESS <i>201 E. 33rd St (18)</i>		22e. DATE SIGNED <i>1/2/67</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE THEREOF <i>1-7-67</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Gardens of Faith</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Md.</i>		
24. FUNERAL DIRECTOR <i>Leonard J. Kuck Inc Baltimore, Md.</i>		ADDRESS		25a. RECD BY REGISTRAR DATE JAN 10 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

28100

PLEASE DO NOT LITTER

28100

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00124

CERTIFICATE OF DEATH

00125

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT GEO G. MEADE		c. LENGTH OF STAY IN lb 45 Min	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kimbrough Army Hospital			
3. NAME OF DECEASED (Type or print)	First BERTRAN	Middle	Last JOSEPH
S. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH April 1913
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired serviceman		11b. KIND OF BUSINESS OR INDUSTRY U.S. Air Force	
13. FATHER'S NAME Melville M. Joseph		14. MOTHER'S MAIDEN NAME Jessie Brown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. 1 Aug 66 558-10-1036	
17. INFORMANT		Address Alexander, Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH 6 hrs	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <i>420.1</i>		Acute myocardial infarction	
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b)		Arteriosclerotic Heart Disease	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 15 Jan 1967 , to 15 Jan 1967 , that death occurred at 10 p.m. , from the causes and on the date stated above.			
22e. SIGNATURE <i>Carl S. Rosen</i>		M.D.	
22c. PHYSICIAN'S NAME (Type) CARL S. ROSEN, CPT, MC		ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>
22d. ADDRESS KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD		22b. DATE SIGNED 15 Jan 67	

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1-19-67	23c. NAME OF CEMETERY OR CREMATORIAL Arlington National	23d. LOCATION (City, town or county) Fort Meade, Va.
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Wernau		ADDRESS Hermann Funeral Home, Alexandria, Va.	25a. REC'D BY REGISTRAR DATE JAN 20 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00125

CERTIFICATE OF DEATH

00126

1. PLACE OF DEATH o. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 1 hr. 15 min	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alice		First Lillian	Middle JOYCE
4. DATE OF DEATH 1		Month 1	Doy Year 6 19 67
S. SEX Female	6. COLOR OR RACE "hite	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-31-10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME J Lester Clark		14. MOTHER'S MAIDEN NAME Mary B. Karnes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. 578-18-3171	
17. INFORMANT R Vernon Joyce Tracey Lansing Md		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypotension		INTERVAL BETWEEN ONSET AND DEATH 39-8	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 116X		DUE TO (b) Congestive Heart Failure	
		DUE TO (c) Rheumatic heart disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 6 , 19 67 to Jan. 6 , 19 67 , that (I) (we) last saw the deceased alive on Jan. 6 , 19 67 , and that death occurred at 3:30 P.M. from causes and on the date stated above.		22b. DATE SIGNED 1/21/67	
22c. PHYSICIAN'S NAME (Type) R. Biern		22d. ADDRESS Annapolis Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-9-67	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Hillcrest		23d. LOCATION (City or Town) (County) (State) Annapolis, Md.	
24. FUNERAL DIRECTOR TA Hardisty 12 Ridgely Ave, Annapolis, Md		25a. REC'D. BY REGISTRAR JAN 18 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00126

CERTIFICATE OF DEATH

00127

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville		c. LENGTH OF STAY IN lb 8 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Knollwood Manor Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Helen M. Kaiss		First Helen	Middle M.
Last Kaiss		4. DATE OF DEATH January 29,	Month January
S. SEX Female	5. COLOR OR RACE Caucasian	6. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
7. B. DATE OF BIRTH March 30, 1891		8. AGE (In years lost birthday) 75 yrs.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Salem, New Hampshire		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W. Pierce		14. MOTHER'S MAIDEN NAME Clara A. Armour	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service no		16. SOCIAL SECURITY NO. 214-54-1680	
17. INFORMANT Kenneth P Daly (son)		Address 11 King Street Cambridge, Massachusetts	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 1 day	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) --- (c) ---			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis, general and cerebral		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) South River Medical Center Edgewater, Maryland 21037
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 30, 1965 , to January 29 1967 , that (I) (we) last saw the deceased alive on January 8, 1967 , and that death occurred at 10:15 AM , from causes and on the date stated above.		22b. DATE SIGNED January 29 1967	
22a. SIGNATURE Charles W. Kinzer		M.D. <input type="checkbox"/> ATTENDING PHYS. Charles W. Kinzer, M. D.	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Charles W. Kinzer, M. D.		22d. ADDRESS South River Medical Center Edgewater, Maryland 21037	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 30, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL Epiphany Episcopal Cem.		23d. LOCATION (City or Town) (County) (State) Odenton A.A. Md.	
24. FUNERAL DIRECTOR Beverley E. Hopping		ADDRESS Beverley E. Hopping Annapolis, Md.	25a. REC'D BY REGISTRAR JAN 31 1967
Hopping Funeral Home		DATE	25b. REGISTRAR'S SIGNATURE Charles W. Kinzer

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00127

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00128

1. PLACE OF DEATH a. COUNTY Anne Arundel			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville			c. LENGTH OF STAY IN 1b Minutes		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt. 424 and Patuxent River.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) EDGAR A. KEMP			First	Middle	Lost
4. DATE OF DEATH January 22 1967	Month	Doy	Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 18 May 1942	9. AGE (In years last birthday) 24 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Arthur L. Kemp, Sr.		14. MOTHER'S MAIDEN NAME Alice May Trail		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-40-1341		17. INFORMANT Address Mrs. Connie Kemp, same as 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound of Chest. DUE TO 919.8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO lost. (c)					
INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Accidental discharge of rifle while target shooting.			
20c. TIME OF INJURY Month, Day, Year Hour XXXXX p.m. 1/22 1967		20d. INJURY OCCURRED 2 While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Field	
20f. (City or town) A.A.		(County) Md.		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Charles S. Petty</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Petty		22. DATE SIGNED 1/23/67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 25 Jan. 1967		23c. NAME OF CEMETERY OR CREMATORIAL Glen Haven Memorial	
23d. LOCATION (City or Town) Glen Burnie, Md.		(County) Md.		(State)	
24. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.		ADDRESS		25a. REC'D BY REGISTRAR JAN 26 1967	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after

death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										CERTIFICATE OF DEATH		00128							
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)														
a. COUNTY Anne Arundel					a. STATE Maryland					b. COUNTY Anne Arundel									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft G.G. Meade, Maryland					c. LENGTH OF STAY IN 1b DOA					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft Geo G. Meade, Maryland									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kimbrough Army Hospital					d. STREET ADDRESS 1858-E Patton Drive					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Marika Levette King					4. DATE OF DEATH Month Day Year January 1 1967					9. AGE (In years last birthday) IF UNDER 1 YEAR Months Deys Hours Min. 2 mo. yrs.									
5. SEX Female					6. COLOR OR RACE Negro					8. DATE OF BIRTH 21 October 1966					10. KIND OF BUSINESS OR INDUSTRY None				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None					11. BIRTHPLACE (County & State, or foreign country) Ft Geo G. Meade, Maryland					12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME Hebert King					14. MOTHER'S MAIDEN NAME Odessa L. Drake					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service) NO N/A					16. SOCIAL SECURITY NO. None				
17. INFORMANT Hebert King(F) Ft G.G. Meade, Maryland					18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crib Death (Pending autopsy)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH				
773.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)					DUE TO DUE TO DUE TO														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										20. WAS ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased at 1025, 1 Jan 1967 and the deceased was DOA at 1025 AM , from the causes and on the date stated above.										22a. SIGNATURE Burton A. Johnson, CPT MC M.D.									
22c. PHYSICIAN'S NAME (Type) BURTON A. JOHNSON, CPT, MC										ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22b. DATE SIGNED 1 Jan 67				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					23b. DATE THEREOF Jan. 9, 1967					23c. NAME OF CEMETERY OR CREMATORIAL ARLINGTON NATIONAL CEM.					23d. LOCATION (City, town or county) ARLINGTON, VIRGINIA				
24. FUNERAL DIRECTOR'S SIGNATURE Charles Wally, Laurel, Md					ADDRESS 6-237420					25a. REC'D BY REGISTRAR JAN 25 1967					25b. REGISTRAR'S SIGNATURE Charles Judge				
VR A15 (4) 20M 5-63																			

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Левити

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Баланс, симулятор

Мини-мобилка

Мини-мобилка

Симулятор полета в космос

Симулятор полета в космос

Баланс, симулятор

Баланс, симулятор

Баланс, симулятор (без пульта)

Баланс, симулятор (без пульта)

Баланс, симулятор

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Баланс, симулятор

Баланс, симулятор

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00129

CERTIFICATE OF DEATH

00130

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN Tb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hanover				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital			d. STREET ADDRESS Box 4 Chesapeake Trailer Court			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First OLLIE	Middle	Lost KING	4. DATE OF DEATH Month January	Day 10	Year 19 67	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 12 Dec. 1888	9. AGE (In years at birthday) 78 yrs.	10. IF UNDER 1 YEAR Months 7	11. IF UNDER 24 HRS. Days 8	12. IF UNDER 24 HRS. Hours 10	13. CITIZEN OF WHAT COUNTRY? U.S.A.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) (ret) Electrician			10b. KIND OF BUSINESS OR INDUSTRY Local Union 24	11. BIRTHPLACE (County & State, or foreign country) Ill.				
13. FATHER'S NAME Chris King			14. MOTHER'S MAIDEN NAME Elizabeth (Unknown)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. 216-10-0628	17. INFORMANT Marie H. King - Same as # 2	Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause { (b) (c) DUE TO (b) (c) DUE TO (c) (c)								INTERVAL BETWEEN ONSET AND DEATH Coronary Thrombosis Arteriosclerotic heart disease
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 55 Jon 10	20f. (City or town) Baltimore	(County) Md.	(State) MD		
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on Dec 21 1966 , and that death occurred at 1:00 A.M. from causes and on the date stated above.								
22a. SIGNATURE Joseph Taler		M.D. <input type="checkbox"/> ATTENDING PHYS. JOSEPH TALER	MED. DIRECTOR <input type="checkbox"/> John Taler	STAFF PHYS. <input type="checkbox"/> John Taler	22b. DATE SIGNED 1/1/67			
22c. PHYSICIAN'S NAME (Type) JOSEPH TALER		22d. ADDRESS 95 Apusker Rd.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/13/67	23c. NAME OF CEMETERY OR CREMATORIAL Glen Haven Memorial Pk.		23d. LOCATION (City or Town) Glen Burnie, Md.	(County) Md.	(State) MD	
24. FUNERAL DIRECTOR Robert Purse			ADDRESS Singleton Funeral Home/ Glen Burnie, Md.	25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge		

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 3 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater - RURAL		d. STREET ADDRESS Rt. 3, Box 759B	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Andrew KNOBLOCK		First William	Middle Andrew
Last KNOBLOCK		4. DATE OF DEATH January 27, 1967	Month Day Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	B. DATE OF BIRTH November 2, 1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET CITY GOVT.		10b. KIND OF BUSINESS OR INDUSTRY Govt	11. BIRTHPLACE (County & State, or foreign country) NCANAAN, New York
13. FATHER'S NAME BALTICE KNOBLOCK		14. MOTHER'S MAIDEN NAME Anna F. FREY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or date of service) yes WW (I)		16. SOCIAL SECURITY NO. HELEN B. KNOBLOCK #2	17. INFORMANT Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 451X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Seoul = Ryland Aldair		DUE TO (b) Aggravated Anemia	
DUE TO (c) Aggravated Anemia		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. Jan 21 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) Cathedral St., Annapolis, Md.
20f. (City or town) (County) (State)			
21. I certify that (I) (the physician) attended the deceased from Jan. 24, 1967 , to Jan. 27, 1967 , that (I) (we) last saw the deceased alive on Jan. 27, 1967 , and that death occurred at 1:10 A.M. M. from causes and on the date stated above.		22b. DATE SIGNED 1/27/67	
22c. SIGNATURE Stephen B. Hiltabiddle		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 121 Cathedral St., Annapolis, Md.
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-29-1967	23c. NAME OF CEMETERY OR CREMATORIAL MAIN STREET CEM.
24. FUNERAL DIRECTOR JOHN M. TAYLOR-SONS ANNAPOLIS MD		ADDRESS	25a. REGD. BY REGISTRAR DATE JAN 30 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00131

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY A.A.C.O. MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SEVERNA PARK				c. LENGTH OF STAY IN lb			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RIVERDALE RD.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Rosa		First Virginia	Middle KNOWLES	Lost	4. DATE OF DEATH Month 1	Doy 16	Year 1967
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-20-1886		9. AGE (In years last birthday) 80 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Dys 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (County & State, or foreign country) ST. MARGARET'S, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME UNK		14. MOTHER'S MAIDEN NAME UNK		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			
16. SOCIAL SECURITY NO. 11111 M. PRAGEL #2		17. INFORMANT Lillian M. Pragel		Address #2			
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Pulmonary Edema DUE TO (b) Generalized arteriosclerosis DUE TO (c) Asthma INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Doy, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Annapolis (County) Anne Arundel (State) M.D.	
21. I certify that (I) (this hospital) attended the deceased from Jan 15 1957 , to Jan 18 1967 , that (I) (we) last saw the deceased alive on Jan 15 1957 , and that death occurred at 8 A.M. from causes and on the date stated above.							
22a. SIGNATURE Francis I. Codd				22b. DATE SIGNED 1-16=67			
22c. PHYSICIAN'S NAME (Type) Francis I. Codd M.D.				22d. ADDRESS Severna Park, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-18-67		23c. NAME OF CEMETERY OR CREMATORIAL CEDAR Bluff		23d. LOCATION (City or Town) Annapolis (County) Anne Arundel (State) M.D.	
24. FUNERAL DIRECTOR John M. Taylor Sons Annapolis, Md.				ADDRESS			
25a. REC'D BY REGISTRAR JAN 18 1967				25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1. PLACE OF DEATH o. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 38 Pinkney St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Thomas		First NMN	Middle KYLER
4. DATE OF DEATH January 19 1967	Month Year	Doy	Year
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1906
9. AGE (In years last birthday) 60 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumbers Helper	10b. KIND OF BUSINESS OR INDUSTRY *****	11. BIRTHPLACE (County & State, or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME Thomas Kyler			
14. MOTHER'S MAIDEN NAME Airy Crampton			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give war or dates of service No		16. SOCIAL SECURITY NO. 219-05-1006	17. INFORMANT Address Florence Green 817 Spa Rd, Anna, Md
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction INTERVAL BETWEEN ONSET AND DEATH 6 days			
DUE TO (b) Coronary artery Disease			
DUE TO (c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1-1567
20f. (City or town) HG		(County) 61	(State)
21. I certify that (I) (this hospital) attended the deceased from 1-1567 , 19, to 1-19 , 61, that (I) (we) last saw the deceased alive on 1-19-67 , 19, and that death occurred at HG M. from causes and on the date stated above.			
22a. SIGNATURE J. C. COOKE		22b. DATE SIGNED 1-22-69	
22c. PHYSICIAN'S NAME (Type) AT ALLEN		22d. ADDRESS 62 Cathedral St	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-24-67	23c. NAME OF CEMETERY OR CREMATORIAL Brewer Hill
23d. LOCATION (City or Town) Annapolis		(County) A.A. Co	(State) Md
24. FUNERAL DIRECTOR C.E. Hicks, III		ADDRESS Annapolis, Md	25a. REC'D BY REGISTRAR DATE JAN 27 1967
			25b. REGISTRAR'S SIGNATURE j Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00133

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TDWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN TB ½ hour		c. CITY OR TDWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		d. STREET ADDRESS 429 Severn View Drive	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Robert Irving Lansdown Sr.		First	Middle	Lost	4. DATE OF DEATH January 22 1967	Month	Doy Year
S. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	8. DATE OF BIRTH 30 May 1887	9. AGE (In years lost birthday) 79 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. DAYS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during past of working life even if retired) Ret. Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy Dept.		11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alexander Lansdown				14. MOTHER'S MAIDEN NAME Carrie M. Porter			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Ruth Wiltshire (daughter)		Address same address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction (suspected)						INTERVAL BETWEEN ONSET AND DEATH ½ hour	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. H20.1		DUE TO (b) Arteriosclerosis, general & coronary	DUE TO (c) -----				many years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary emphysema, Urinary tract infection						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 10 June 1966 , to 22 Jan. 1967 , that (I) (we) last saw the deceased alive on 3 Jan. 1967 , and that death occurred at 4:42 P.M. from causes and on the date stated above.							
22a. SIGNATURE Charles W. Kinzer		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 22 Jan. 1967			
22c. PHYSICIAN'S NAME (Type) Charles W. Kinzer, M. D.		22d. ADDRESS South River Medical Bldg. Edgewater, Maryland 21037					
23a. BURIAL, CREMATION, BURNED (Specify) Burial		23b. DATE THEREOF 1/25/67	23c. NAME OF CEMETERY OR Crematory Ft. Lincoln		23d. LOCATION (City or Town) Colmar Manor		(County) P. G. Md.
24. FUNERAL DIRECTOR Francis Gasch's Sons		ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR JAN 26 1967		25b. REGISTRAR'S SIGNATURE Franklin Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00134

CERTIFICATE OF DEATH

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville, Md.		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater		d. STREET ADDRESS Rt 2 Box 200		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Knollwood Nursing Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Nora Beard		First	Middle	Last	4. DATE OF DEATH Jan. 15 1967	Month	Day	Year
S. SEX female	6. COLOR OR RACE white	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 1884	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (County & State, or foreign country) Rockbridge, Va.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William B. Beard				14. MOTHER'S MAIDEN NAME Julia F. Clark				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 231-60-2235A		17. INFORMANT Mrs. Frances L. Woolwine - same as #2 above		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure						INTERVAL BETWEEN ONSET AND DEATH		
422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) Arteriosclerotic Cardiovascular disease		DUE TO (c) Anemia				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic cystitis & pyelonephritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at _____ M, from causes and on the date stated above.		22b. DATE SIGNED Jan 15, 1967						
22a. SIGNATURE Ray M. Smith M.D.		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) RAY M. SMITH M.D.		22d. ADDRESS SEVERNA PARK, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/15/67	23c. NAME OF CEMETERY OR CREMATORIAL Presbyterian Cemetery		23d. LOCATION (City or Town) (County) (State) Lynchburg			Campbell Va.
24. FUNERAL DIRECTOR Beverley E. Hopping		ADDRESS Beverley E. Hopping	25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE J Charles Judge			DATE JAN 17 1967
HOPPING FUNERAL HOME - Annapolis, Md.								

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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00135

CERTIFICATE OF DEATH

00136

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Baltimore		c. LENGTH OF STAY IN lb 25 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Baltimore				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 211 Audrey Ave.				d. STREET ADDRESS 211 Audrey Ave.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First ALBIN	Middle NMN	Lost LECHOWICZ	4. DATE OF DEATH January 24	Month January	Day 24	Year 1967
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 19, 1893	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Iron Worker		10b. KIND OF BUSINESS OR INDUSTRY Ship Building		11. BIRTHPLACE (County & State, or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Carl Lechowicz				14. MOTHER'S MAIDEN NAME Pauline ----				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-05-7407		17. INFORMANT Mrs. Albin Lechowicz (same)		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO				<i>Congestive heart failure</i> 1 month				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Glen Burnie	(County) Baltimore Co.	(State) Md.		
21. I certify that (I) (this hospital) attended the deceased from Jan. 11, 1967 , to Jan. 24, 1967 , that (I) (we) last saw the deceased alive on Jan. 24, 1967 , and that death occurred at 7 YEA M, from causes and on the date stated above.								
22a. SIGNATURE <i>Robert Dabolins</i>				M.D. <input checked="" type="checkbox"/> ATTENDING PHYS.	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED Jan. 24, 1967	
22c. PHYSICIAN'S NAME (Type) Dr. Robert Dabolins				22d. ADDRESS 400 Crain Highway, N.W., Glen Burnie				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 27, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Holy Cross Cemetery	23d. LOCATION (City or Town) (County) (State) Ritchie Hwy., A.A.C., Md.				
24. FUNERAL DIRECTOR George J. Gonce-4001 Ritchie Hwy., Baltimore		ADDRESS		25a. REC'D BY REGISTRAR JAN 31 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00136

CERTIFICATE OF DEATH

00137

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville 11 days		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) #34194 First Calvert Middle George Last Litz		4. DATE OF DEATH Month 1 Day 10 Year 1967	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/9/16
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labored		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Litz		14. MOTHER'S MAIDEN NAME Wolfe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. 216-01-8467	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure INTERVAL BETWEEN ONSET AND DEATH 581.1			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Cirrhosis of Liver			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (c) Chronic Alcoholism			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour o.m. ----- 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) -----
20f. (City or town) BALTO. (County) Md. (State) Md.			
21. I certify that (I) (this hospital) attended the deceased from 12/30/1966 , to 1/10/1967 , that (I) (we) last saw the deceased alive on 1/10/1967 , and that death occurred at 2:AM , from causes and on the date stated above.			
22a. SIGNATURE <i>L. Benedict, M.D.</i>		22b. DATE SIGNED 1/10/67	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.		22d. ADDRESS Crownsville State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-13-67	
23c. NAME OF CEMETERY OR CREMATORIAL BALTO. NATIONAL Cem.		23d. LOCATION (City or Town) (County) (State) BALTO., Md.	
24. FUNERAL DIRECTOR Harley Miller - 2334		25a. REC'D BY REGISTRAR DATE JAN 12 1967	
ADDRESS Jefferson St.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00137

CERTIFICATE OF DEATH

00138

TO HOSPITAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH

a. COUNTY

Anne Arundel

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

St. Margaret's

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Bay Manor Nursing Home

3. NAME OF
DECEASED
(Type or print)

First

Middle

James

John

Lorens

5. SEX

6. COLOR OR RACE

male

white

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

blacksmith

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years last birthday)

August 9, 1875

91 yrs.

13. FATHER'S NAME

James Lorens

10b. KIND OF BUSINESS OR INDUSTRY

Boundary

11. BIRTHPLACE (County & State, or foreign country)

Germany

12. CITIZEN OF WHAT COUNTRY?

USA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

no

16. SOCIAL SECURITY NO.

219-16-1475

17. INFORMANT

Mrs. Lillian Darden

Address

same as #2 above

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

33IX

DUE TO

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause first.

(b)

DUE TO

(c)

Cerebral Vascular Accident
Cerebral Vascular insufficiencyINTERVAL BETWEEN
ONSET AND DEATH2 days
Unknown

MEDICAL CERTIFICATION

20c. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY PERFORMED?

YES NO 20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m. While at work Not White at work
p.m. 1920d. INJURY OCCURRED
While at work Not White at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from..... 8/2 1965, to 1/23 1967, that (I) (we) last saw the deceased alive on..... 1/20 1967, and that death occurred at 8:30 AM, from the causes and on the date stated above.

22a. SIGNATURE

Richard I. Hochman

M.D.

ATTENDING PHYS.

MED. DIRECTOR

 STAFF PHYS. 22b. DATE SIGNED
1/23/67

22c. PHYSICIAN'S NAME (Type)

Richard I. Hochman, M.D.

M.D.

ATTENDING PHYS.

MED. DIRECTOR

 STAFF PHYS.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF
Jan. 25, 1967

23c. NAME OF CEMETERY OR CREMATORIAL

Bohemian National Cem.

23d. LOCATION (City, town or county)

Baltimore City

(State)

Maryland

24 FUNERAL DIRECTOR'S SIGNATURE

Beverley E. Hopping
Hopping Funeral Home

ADDRESS

Beverly E. Hopping
Annapolis, Md.

25e. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE
Charles Judge

DATE

JAN 26 1967

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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00138

CERTIFICATE OF DEATH

00133

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-GLEN BURNIE	c. LENGTH OF STAY IN lb 2 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-BALTIMORE #25 02.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NORTH ARUNDEL HOSPITAL 54		d. STREET ADDRESS 318 SNOW HILL ROAD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MALACHI		First LOVE	Middle LOVE
S. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH JANUARY 1, 1903		9. AGE (In years lost birthday) 64 yrs.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY cementary	
11. BIRTHPLACE (County & State, or foreign country) NEW PORT NEWS, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Love		14. MOTHER'S MAIDEN NAME Elizabeth Holloman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Alonzo Love	
17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Acute Myocardial Infarction - 420.1			
DUE TO			
(b) CARDIAC DECOM PENSATION -			
DUE TO			
(c) ACUTE-ANTERIOR LATERAL MYOCARDIAL INFARCTION 20-			
INTERVAL BETWEEN ONSET AND DEATH 1H -			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
HYPERTENSION. - DIABETIS MELLITUS. -			
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 23, 1967, to Jan 25, 1967, that (I) (we) last saw the deceased alive on Jan 25, 1967, and that death occurred at 10:05M, from causes and on the date stated above.			
22a. SIGNATURE Dr. Carlos E. Arrabal		22b. DATE SIGNED Jan 25-1967	
22c. PHYSICIAN'S NAME (Type) CARLOS E ARRABAL		22d. ADDRESS 2705 MOUNTAIN RD - PASADENA 24222	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial Jan 29/67		23b. DATE THEREOF Jan 29/67	
23c. NAME OF CEMETERY OR CREMATORIAL Mt. Calvary Cem		23d. LOCATION (City or Town) (County) (State) A. G. County Md	
24. FUNERAL DIRECTOR José A. Elickson 1/29/67. Casketed		25a. ADDRESS	
25b. REC'D BY REGISTRAR Date JAN 30 1967		25b. REGISTRAR'S SIGNATURE Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

00139

CERTIFICATE OF DEATH

00140

1. PLACE OF DEATH o. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 4 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		d. STREET ADDRESS Barbud Lane	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Helen		First June	Middle LUTTRELL
Last January		4. DATE OF DEATH 20	Month Year 1967
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
		DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH April 20, 1916
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME HARRY HUNZIKER		14. MOTHER'S MAIDEN NAME EVA B. HARRISON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. - - -	
17. INFORMANT RICHARD E. LUTTRELL SR #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 171X		INTERVAL BETWEEN ONSET AND DEATH 84 hrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Due to Car accident Meloidosis		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) John Taylor attended the deceased from Jan. 20, 1967 , to Jan. 20, 1967 , that (I) John Taylor last saw the deceased alive on Jan. 20, 1967 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE John Taylor		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 6:45 pm 1/20/67
22c. PHYSICIAN'S NAME (Type) E. Luttrell		22d. ADDRESS Annapolis Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-24-67	23c. NAME OF CEMETERY OR CREMATORIAL SHERWOOD CEM.
24. FUNERAL DIRECTOR JOHN M. TAYLOR SON Annapolis MD		ADDRESS	25a. REC'D BY REGISTRAR DATE JAN 24 1967
			25b. REGISTRAR'S SIGNATURE Charles J. Taylor

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Lebanon 1940

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00140

CERTIFICATE OF DEATH

00141

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN lb 18yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		d. STREET ADDRESS #113 Kent Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) #113 Kent Road (Glen Gardens)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HECTOR (nmi)		First Mac Donald	Middle Last Month Year Month Doy Year 4, 19 67
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (County & State, or foreign country) Sydney, Nova Scotia		9. AGE (In years last birthday) 61 yrs.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John J. Mac Donald	
14. MOTHER'S MAIDEN NAME Margaret C. Mc Allister		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 168-09-1365		17. INFORMANT Address Mrs. Nellie M. Mac Donald (wife) Same as	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ DUE TO lost. (c) _____			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Diabetes Mellitus			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 204 Crain Hwy SW Glen Burnie
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Sept 31, 1966 , to Oct 4, 1966 , that (I) (we) last saw the deceased alive on Sept 30, 1966 , and that death occurred at 5:21 PM , from causes and on the date stated above.			
22a. SIGNATURE C.R. Mac Donald MD		22b. DATE SIGNED 1/6/1966	
22c. PHYSICIAN'S NAME (Type) C.R. Mac Donald MD		22d. ADDRESS 204 Crain Hwy SW Glen Burnie	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 7, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven Cemetery
24. FUNERAL DIRECTOR RICHARD V. SINGLETON		23d. LOCATION (City or Town) (County) (State) Wheaton, Maryland	
ADDRESS Glen Burnie, Md.		25a. REC'D BY REGISTRAR JAN 9 1967	25b. REGISTRAR'S SIGNATURE James J. Geage

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REF ID: A639100

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00142

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after

death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE WEST VIRGINIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ODENTON		b. COUNTY MARSHALL	
c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MOUNDSVILLE	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1592 ANNAPOLIS ROAD		d. STREET ADDRESS 1002 LAFAYETTE AVE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First OLIVER	Middle C. J	Last MAGERS
4. DATE OF DEATH	Month JANUARY	Day 21	Year 1967
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 DECEMBER 1929
9. AGE (In years last birthday) 37 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SOLDIER	11. KIND OF BUSINESS OR INDUSTRY US ARMY	12. BIRTHPLACE (County & State, or foreign country) MOUNDSVILLE, W. VIRGINIA
13. CITIZEN OF WHAT COUNTRY? USA	14. MOTHER'S MAIDEN NAME ANNA ELIZABETH (MAIDEN NAME UNKNOWN)		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES	16. SOCIAL SECURITY NO. 11 YRS 4MO	17. INFORMANT ANNA ELIZABETH MAGERS (M) MOUNDSVILLE W. VA.	Address 1002 LAFAYETTE AVE
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EPIDURAL HEMATOMA <i>936.9</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SECONDARY TO TRAUMA			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) CIRCUMSTANCES UNKNOWN	
20c. TIME OF INJURY Hour e.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that THEODORE F. TOULAN the deceased WAS DOA 21 Jan 1967 , from the causes and on the date stated above.			
22a. SIGNATURE <i>Theodore F. Toulan</i>		M.D.	22b. DATE SIGNED 21 JANUARY 1967
22c. PHYSICIAN'S NAME & TITLE THEODORE F. TOULAN, CPT, MC		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22d. ADDRESS KIMBROUGH ARMY HOSPITAL FT GEO G. MEADE, MD
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF Jan. 26, 1967	23c. NAME OF CEMETERY OR CREMATORIAL River View Cemetery	23d. LOCATION (City, town or county) Moundsville, West Virginia
24. FUNERAL DIRECTOR'S SIGNATURE Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland		ADDRESS	25a. REC'D BY REGISTRAR Charles Judge
			25b. REGISTRAR'S SIGNATURE

20100

20100



June 1st 1867

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00143

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00143

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie.</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brooklyn Park - Secto 25</i>		
c. LENGTH OF STAY IN lb			d. STREET ADDRESS <i>4100 Belgrave Road</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>North Arundel Hospital</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Rita</i>			First <i>R</i>	Middle <i>I</i>	Last <i>MAN</i>
S. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-14-66</i>	9. AGE (In years lost birthday) <i>80 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md</i>	
13. FATHER'S NAME <i>Daniel Pfeltz</i>			14. MOTHER'S MAIDEN NAME <i>Anna Rhoades</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Family</i>	
Address <i>Same</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <i>Chronic myocarditis - Death</i>					
DUE TO <i>hypertensive failure - uremia</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause { (b) <i>Hypertension</i> (c) <i>Uremia</i>					
INTERVAL BETWEEN ONSET AND DEATH <i>15 hours.</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)					
<i>Fracture left femur.</i>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>Fell at home</i>			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <i>Home</i>		20f. (City or town) (County) (State) <i>Brooklyn Park</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>E. Burkhardt</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		22. DATE SIGNED <i>1-27-67</i>	
EXAMINER'S NAME (Type) <i>E. Burkhardt</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1/25/67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill</i>		23d. LOCATION (City or Town) (County) (State) <i>AA Co Md</i>
24. FUNERAL DIRECTOR <i>McCully F H 237 Patapsco Ave</i>		ADDRESS <i>21225</i>		25a. REC'D BY REGISTRAR DATE <i>JAN 24 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

64100

Item 10 READING MATERIALS INDEX

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about books

about

books

DEPT OF EDUCATION LIBRARY

EDUCATIONAL DOCUMENTS

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00143

CERTIFICATE OF DEATH

00145

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		b. COUNTY Anne Arundel	
c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		d. STREET ADDRESS #10 "D" Street S/W	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ALBERT		First GEORGE	Middle MARINER JR.
4. DATE OF DEATH May 16 1967	Month May	Doy 16	Year 1967
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY US Civil Service	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Albert G. Mariner		14. MOTHER'S MAIDEN NAME Martha Wolf	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215/03/7179	
17. INFORMANT Mrs. Doris R. Mariner		Address Same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 420.0		INTERVAL BETWEEN ONSET AND DEATH months	
DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b)		myocardial failure	
DUE TO (c)		Arteriosclerotic Heart Disease	
9-12 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Pikesville
(County) Pikesville		(State) Md.	
21. I certify that (I) (this hospital) attended the deceased from July , 19 66 , to Jan , 19 67 , that (I) (we) last saw the deceased alive on Jan 10 1967 , and that death occurred at Glen Burnie , M., fram causes and on the date stated above.			
22a. SIGNATURE Hilary Mariner		22b. DATE SIGNED 1-17-67	
22c. PHYSICIAN'S NAME (Type) H.T.O.H.E		22d. ADDRESS 5 Central Ave. Glen Burnie, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 19, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL Druid Ridge Cemetery		23d. LOCATION (City or Town) (County) (State) Pikesville Md.	
24. FUNERAL DIRECTOR R.V. SINGLETON		ADDRESS GLEN BURNIE, MD.	
25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE JAN 19 1967	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and many event, within 72 hours after death.

00146

CERTIFICATE OF DEATH

00146

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis 02/1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 4 Severn Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Martha Ann		First Middle Last	4. DATE OF DEATH Month Doy Year MAY 5 19 67
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH June 21, 1925		9. AGE (In years lost birthday) 41 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERVISOR		10b. KIND OF BUSINESS OR INDUSTRY RETAIL STORE	
11. BIRTHPLACE (County & State, or foreign country) WHEELING WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME THOMAS Butterworth		14. MOTHER'S MAIDEN NAME CHARA Scott	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <u>Pneumonia</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>			
162.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchogenic carcinoma</u> ? DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7-21</u> , 19 <u>66</u> , to <u>1-5-</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1-4</u> , 19 <u>67</u> and that death occurred at <u>4:55 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Barber C. Palmer</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 1/5/67
22c. PHYSICIAN'S NAME (Type) Barber C. Palmer, M.D.		22d. ADDRESS 121 Cathederal St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-9-67	23c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat'l. Arlington Va.
24. FUNERAL DIRECTOR John M. Taylor Annapolis, Md.		ADDRESS	25a. REC'D BY REGISTRAR DATE JAN 10 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00145

CERTIFICATE OF DEATH

00147

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Hanover</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN lb <u>4 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>316 Zeppelin Ave</u>		d. STREET ADDRESS <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>#24760</u>		First <u>Arich</u>	Middle <u></u>	Lost <u>McClain</u>	4. DATE OF DEATH <u>1 23 1967</u>	Month <u>1</u>	Doy <u>23</u>	Year <u>1967</u>	
S. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED WIDOWED <u>Sep.</u>	NEVER MARRIED DIVORCED <u></u>	8. DATE OF BIRTH <u>--1920</u>	9. AGE (In years lost birthday) <u>47 yrs.</u>	IF UNDER 1 YEAR Months <u></u>	IF UNDER 24 HRS. DAYS <u></u>	Hours <u></u>	Min. <u></u>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Constructionist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Dan McClain</u>		14. MOTHER'S MAIDEN NAME <u>Zelma Lewis</u>		Address					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Hospital Records</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>134.1</u>		DUE TO <u>Epilepsy - Torula Encephalitis</u>		INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <u>lost</u>		(b) <u></u>							
(c) <u></u>		DUE TO <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>							
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____ <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>			
21. I certify that (I) (this hospital) attended the deceased from <u>1/28/1963</u> , to <u>1/23/1967</u> , that (I) (we) last saw the deceased alive on <u>1/23/1967</u> , and that death occurred at <u>1:30 M</u> , from causes and on the date stated above.									
22a. SIGNATURE <u>Hildagard Heard Reissman</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		P. MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/23/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Hildagard Heard Reissman, M.D.</u>		22d. ADDRESS <u>Crownsville State Hospital Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE THEREOF <u>1/24/67</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Milligan</u>		23d. LOCATION (City or Town) (County) (State) <u>Whiteville - N.C.</u>			
24. FUNERAL DIRECTOR <u>Monahan P.S. Wager 638 N. Common St.</u>		ADDRESS <u></u>		25a. REC'D BY REGISTRAR DATE <u>JAN 24 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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MAIL TO 75100

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2825

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <i>Alex Co</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Alex Co</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ARNOLD</i>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ARNOLD, Md</i>			d. STREET ADDRESS <i>Middleway Rd</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Jessie G</i>			First	Middle	Last	4. DATE OF DEATH Month <i>Jan</i> Day <i>15</i> Year <i>1967</i>					
S. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 31, 1892</i>			9. AGE (In years lost birthday) <i>74 yrs.</i>			IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>			11. BIRTHPLACE (County & State, or foreign country) <i>Easton, Md</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>George R. Jones</i>						14. MOTHER'S MAIDEN NAME <i>Emma P. Wales</i>			Address <i>Arnold, Md</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>			16. SOCIAL SECURITY NO. <i>330-48-7506</i>			17. INFORMANT <i>BARBARA Sanders</i>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i> DUE TO <i>332X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Cerebral arteriosclerosis</i> DUE TO <i>few hours</i>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			INTERVAL BETWEEN ONSET AND DEATH		
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>—</i> p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) <i>Annapolis</i> (County) <i>Md</i> (State) <i>Md</i>		
21. I certify that (I) (this hospital) attended the deceased from <i>—</i> , 19 <i>—</i> , to <i>—</i> , 19 <i>—</i> , that (I) (we) last saw the deceased alive on <i>—</i> , 19 <i>—</i> , and that death occurred on <i>10/30/67</i> M, from causes and on the date stated above.											
22a. SIGNATURE <i>Jm Smith</i>			22b. DATE SIGNED								
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1-18-67</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>St Margarets</i>		23d. LOCATION (City or Town) <i>Annapolis</i> (County) <i>Md</i> (State) <i>Md</i>					
24. FUNERAL DIRECTOR		ADDRESS <i>TA Hordeley 12 Ridges, One Annapolis, Md</i>		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>James Judge</i>					
VR A15 (4) 25M 1/67		DATE JAN 25 1967		ADDRESS		DATE					

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00147

CERTIFICATE OF DEATH

00148

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie, Md.		b. COUNTY Anne Arundel	
c. LENGTH OF STAY IN 1b Glen Burnie, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) North Arundel Hospital		d. STREET ADDRESS 104 Ridge Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Charles	Middle Emory	Last Merryman
4. DATE OF DEATH Month January	Day 10	Year 1967	
5. SEX M	6. COLOR OR RACE W W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 6/18/1890
9. AGE (In years last birthday) 76 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Supt.		10b. KIND OF BUSINESS OR INDUSTRY American Oil	
11. BIRTHPLACE (County & State, or foreign country) Balto., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Emory T. Merryman		14. MOTHER'S MAIDEN NAME Genieve Hyle	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-03-5953	
17. INFORMANT		Address Mrs. Pansy V. Merryman same address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).1]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis			
420.1 Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b) Coronary artery disease			
DUE TO (c) ASHD			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Pikesville, Md.
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 9 1967 , to Jan 10 1967 that (I) (we) last saw the deceased alive on Jan 9 1967 and that death occurred at Balto., Md. from the causes and on the date stated above.			
22a. SIGNATURE Joseph Taler		22b. DATE SIGNED Jan 10, 1967	
22c. PHYSICIAN'S NAME (Type) JOSEPH TALER		22d. ADDRESS 95 Monahans Rd. Glen Burnie, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/13/1967	23c. NAME OF CEMETERY OR CREMATORIAL Druid Ridge Cemetery
23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR Wm. J. Gibbons & Sons Balt., Md.		25a. ADDRESS Baltimore, Md.	25b. REGISTRAR'S SIGNATURE Charles J. Moore
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00148

CERTIFICATE OF DEATH

00149

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN lb 2mos. 2 yrs. 3 days	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		d. STREET ADDRESS 908 Boucher Avenue	
3. NAME OF DECEASED (Type or print) 3-#27735		First James	Middle L.
3. SEX Male		6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. NEVER MARRIED <input checked="" type="checkbox"/>		9. DATE OF BIRTH Dec. 16, 1908	
10. AGE (In years last birthday) 58 yrs.		11. IF UNDER 1 YEAR Months 1 Days 30 Hours 19 Min. 67	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith		12. KIND OF BUSINESS OR INDUSTRY -----	
13. FATHER'S NAME James A. Messick		14. MOTHER'S MAIDEN NAME Mary Ellen Thomas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-12-9672	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Hemorrhagic Tracheo-Bronchitis			
16/X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Confluent Bronchopneumonia, Bilateral			
DUE TO (c) Carcinoma of Right Aryepiglottic Fold			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
C.B.S. due to Chronic Alcoholism; Cirrhosis of Liver, PTB, healed			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a.m. --- 19 p.m. ---		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----
20f. (City or town) Riva (County) A.A. (State) Md.			
21. I certify that (I) (this hospital) attended the deceased from 7/16 , 19 64 , to 1/30 , 19 67 , that (I) (we) last saw the deceased alive on 1/30 , 19 67 , and that death occurred at 2:30 M, from causes and on the date stated above.			
22a. SIGNATURE <i>James A. Messick</i>		22b. DATE SIGNED 1/30/67	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.		22d. ADDRESS Crownsville State Hospital, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 2, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Edwards Chapel
23d. LOCATION (City or Town) (County) (State) Riva A.A. Md.		23e. ADDRESS Beverley E. Hopping	
24. FUNERAL DIRECTOR Beverley E. Hopping		25a. REC'D BY REGISTRAR DATE FEB 3 1967	25b. REGISTRAR'S SIGNATURE <i>Beverley E. Hopping</i>
25c. HOPPING FUNERAL HOME Annapolis, Md.			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00149

CERTIFICATE OF DEATH

00150

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)	
<i>J-H Co</i>		a. STATE	<i>Md</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
<i>SEVERNA PARK</i>		<i>J-H Co</i>	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>18 years</i>		<i>Severna Park 02-1</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
<i>HQ 2 Box 284</i>		<i>HQ 2 Box 284</i>	
e. IS RESIDENCE ON A FARM?			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
<i>ANNA</i>	<i>V.</i>	<i>MICHAEL</i>	<i>1 - 7 1967</i>
4. DATE OF DEATH	Month	Day	Year
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
<i>FEMALE</i>	<i>White</i>	<i>WIDOWED <input checked="" type="checkbox"/></i>	<i>9-7-81</i>
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.
<i>85 yrs.</i>		Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country)	
<i>Housewife at home</i>		<i>Baltimore Md 21218</i>	
12. CITIZEN OF WHAT COUNTRY?		<i>USA</i>	
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
<i>George Gornell</i>	<i>Amanda Bentz</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> yes give war or dates of service	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
<i>No</i>		<i>Romanus Miller - alone</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>generalized arteriosclerosis</i>			
4500 DUE TO <i>Cardiac decompensation</i>			
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>generalized arteriosclerosis</i>			
DUE TO (c) <i>Cardiac decompensation</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>			
2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <i>None</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>
20f. (City or town) <i>None</i>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>2/3 1967</i> , to <i>1/7 1967</i> , that (I) (we) last saw the deceased alive on <i>12/19 1967</i> , and that death occurred at <i>10 AM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>R. M. McLaughlin</i>		22b. DATE SIGNED <i>1/7/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>R. M. McLaughlin</i>		22d. ADDRESS <i>3708 Mountain Rd. Pasadena, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1-10-67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>New Haven</i>
24. FUNERAL DIRECTOR <i>West J. Launer Jr.</i>		ADDRESS <i>Severna Park Md</i>	25a. REC'D BY REGISTRAR DATE JAN 11 1967
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00150

00151

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft G.G. Meade, Maryland DOA		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kimbrough Army Hospital, FGGMMD		d. STREET ADDRESS 426 Arbor Drive	
3. NAME OF DECEASED (Type or print) Mary First Middle Last Gladys Miller		4. DATE OF DEATH Month Day Year January 1 1967	
5. SEX Female Cau 6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 25 March 1906	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Fort Dodge, Iowa		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Lilly		14. MOTHER'S MAIDEN NAME Nettie Boyer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service) No None		16. SOCIAL SECURITY NO. 128-09-1746 17. INFORMANT Unknown John T. Mc Coy (SIL) ^{426 Arbor Drive} Glen Burnie, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Cancer 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that the deceased died the deceased was was DOA at on 1220 , 1 Jan 1967, because that death occurred at 1220PM from the causes and on the date stated above.			
22a. SIGNATURE Frederick J. Bachl M.D.		22b. DATE SIGNED 1 January 1967	
22c. PHYSICIAN'S NAME (Type) Frederick J. Bachl, CPT, MC		22d. ADDRESS Kimbrough Army Hospital, Ft G.G. Meade, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/4/1967	
23c. NAME OF CEMETERY OR CREMATORIAL Glen Haven Memorial Pk.		23d. LOCATION (City, town or county) (State) Glen Burnie, Md.	
24 FUNERAL DIRECTOR'S SIGNATURE Raymond C. Fink		ADDRESS Glen Burnie, Md.	
		25a. REC'D BY REGISTRAR DATE JAN 4 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the hospital or attending physician, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00151

CERTIFICATE OF DEATH

00152

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		d. STREET ADDRESS 828 Janice Drive	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First James	Middle KARL	Last MORELAND	4. DATE OF DEATH Month January	Day 27	Year 19 67
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 18, 1914	9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Doys 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER Ret. U.S. GOV'T		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Annapolis, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME JOHN W. MORELAND		14. MOTHER'S MAIDEN NAME MARGARET Watson		Address 21 EASTERN AVE ANNAPOLIS MD			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No; if unknown, if yes give war or date of service) YES		16. SOCIAL SECURITY NO. 216-18-5121		17. INFORMANT Mrs. ROBERT C. HUMMEL		INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Presumably Janice Cirhoug DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ stating the underlying cause (c) _____ DUE TO DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-27-67 to 1-27-67 that (I) (we) last saw the deceased alive on 19 , and that death occurred at 2:50 A.M. M. from causes and on the date stated above.							
22a. SIGNATURE John M. Taylor							
22c. PHYSICIAN'S NAME (Type) J. M. TAYLOR		22d. ADDRESS Annapolis, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-29-1967		23c. NAME OF CEMETERY OR CREMATORIAL HILLCREST Cem.		23d. LOCATION (City or Town) (County) (State) ANNAPOLIS MD.	
24. FUNERAL DIRECTOR JOHN M. TAYLOR SON ANNAPOLIS MD		ADDRESS					
25a. REC'D BY REGISTRAR JAN 30 1967				25b. REGISTRAR'S SIGNATURE Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00152

CERTIFICATE OF DEATH

00154

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY H. A. Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MD. A.A. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Margaret's	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. MARGARET'S	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BROADNECK RD.		d. STREET ADDRESS BROADNECK RD	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First LENA	Middle B.	Last Morton
4. DATE OF DEATH	Month 1	Doy 19	Year 1967
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-31-1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (County & State, or foreign country) LAUREL, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Gustave Smith		14. MOTHER'S MAIDEN NAME Minnie ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT HELEN M. Putnam		Address MAYO, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 420.1 (b) Coronary occlusion DUE TO (c) Arteriosclerotic cardiovascular disease INTERVAL BETWEEN ONSET AND DEATH few hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) SEVERNA PARK MD.
20f. (City or town) SEVERNA PARK		(County) MD.	(State) MD.
21. I certify that (I) (this hospital) attended the deceased from 19 , 19 67 , to 19 , 19 67 , that (I) (we) last saw the deceased alive on 19 , 19 67 , and that death occurred at 2 AM M, from causes and on the date stated above.			
22a. SIGNATURE Ray Smith		22b. DATE SIGNED 1-19-67	
22c. PHYSICIAN'S NAME (Type) Ray Smith		22d. ADDRESS SEVERNA PARK MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-23-67	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Annapolis National
24. FUNERAL DIRECTOR John M. Taylor & Sons Annapolis, Md.		23d. LOCATION (City or Town) Annapolis (County) A. H. Md. (State)	
		25a. REC'D BY REGISTRAR JAN 24 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00153

CERTIFICATE OF DEATH

00155

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 4 months	b. COUNTY Anne Arundel
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mayo	
d. STREET ADDRESS Box 327 - Beverly Beach		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) #33182 Joseph H. Murphy		First Joseph	Middle H.
Last Murphy		4. DATE OF DEATH 12/5/94	Month 1
5. SEX Male		6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12/5/94	9. AGE (In years last birthday) xx 72	IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fed. Gov. (ret.)	10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (County & State, or foreign country) Maryland	IF UNDER 24 HRS. Days 0
12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME John Murphy		
14. MOTHER'S MAIDEN NAME Unknown	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		
16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Hospital Records		Address
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Respiratory Insufficiency			
DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) Emphysema; Bronchectasis			
DUE TO (c) Bronchopneumonia			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) CBS with Cerebral Arteriosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour o.m. ----- 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----
20f. (City or town) (County) (State) -----			
21. I certify that (I) (this hospital) attended the deceased from 9/21 , 19 66 , to 1/31 , 19 67 , that (I) (we) last saw the deceased alive on 1/31 , 19 67 , and that death occurred at 9: P.M. from causes and on the date stated above.			
22a. SIGNATURE L. Benedict			
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 1/4/68
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF 1-7-67	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill
24. FUNERAL DIRECTOR Lee Funeral Home		ADDRESS 300-48 NEDC	23d. LOCATION (City or Town) (County) (State) Anne Arundel
25. REC'D BY REGISTRAR DATE JAN 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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179

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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00154

CERTIFICATE OF DEATH

00156

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY AA MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN lb 7 YRS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie	
3. NAME OF DECEASED (Type or print) Ruth		First Eda	Middle Music
S. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 8-04-06
10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher (Ret.) (A.A. Co. Schools)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Tenn (Cumberland Co.)
13. FATHER'S NAME William Music		14. MOTHER'S MAIDEN NAME Mary Margaret Richards	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Mrs. Thelma M. Lowe (sister) Same as #2
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Carlos Calafate - Progeria</i> DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause (b) <i>Cerebral Embolism - Basilar Artery</i> DUE TO (c) <i>None</i>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>JAN 27, 1967</i> , to <i>JAN 29, 1967</i> , that (I) (we) last saw the deceased alive on <i>JAN 29, 1967</i> , and that death occurred at <i>7:55 PM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Dr Carlos E. Arrabal</i>		22b. DATE SIGNED <i>1-29-67</i>	
22c. PHYSICIAN'S NAME (Type) CARLOS E ARRABAL		22d. ADDRESS <i>2705 Mountain Rd-Pasadena 21122</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 1, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Crossville City Cemetery
23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR Eugene B. Glaneng		25a. ADDRESS Singleton Funeral Home Glen Burnie, Md.	25b. REGISTRAR'S SIGNATURE Charles Judge
VR A15 (4) 20 M 1/66		25c. REC'D BY REGISTRAR DATE JAN 31 1967	

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00155

CERTIFICATE OF DEATH

00157

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS			c. LENGTH OF STAY IN lb 4 days		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) NAVAL HOSPITAL			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First JOSEPH	Middle GEORGE	Last NEIMAN	4. DATE OF DEATH 31 January 1967	Month Day Year
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 October 1894	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LT USN RET		10b. KIND OF BUSINESS OR INDUSTRY NAVY RET		11. BIRTHPLACE (County & State, or foreign country) Hickory Ridge, Pa.	
13. FATHER'S NAME August Neiman			14. MOTHER'S MAIDEN NAME Pauline Hirsch		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 24052391		17. INFORMANT Anna E. Neiman (Wife)	
			Address RFD 5, Box 295 Annapolis, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 525X			Bronchopneumonia		
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO (b) Chronic lung disease with fibrosis (c) and retained foreign material		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 27 JAN 1967 to 31 JAN 1967 , that (I) (we) last saw the deceased alive on 31 Jan 1967 , and that death occurred at 2310M , from the causes and on the date stated above.					
22a. SIGNATURE <i>W. P. Arentzen</i>			22b. DATE SIGNED 2-1-67		
22c. PHYSICIAN'S NAME (Type) W. P. ARENTZEN, CAPT MC USN			22d. ADDRESS		

23a. BURIAL, CREMATION, REMOVALS (Specify) BURIAL	23b. DATE THEREOF 27-4-67	23c. NAME OF CEMETERY OR CREMATORIAL ST. MARGARETS	23d. LOCATION (City, town or county) (State) ST. MARGARETS MD.	
24. FUNERAL DIRECTOR <i>John M. Taylor & Sons</i>	ADDRESS <i>Annapolis, Md.</i>	25a. REC'D BY REGISTRAR EEB 6	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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00156

CERTIFICATE OF DEATH

00158

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - GLEN BURNIE		c. LENGTH OF STAY IN lb 12 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - PASADENA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NORTH ARUNDEL		d. STREET ADDRESS 113 MAGNOLIA AVE.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First MADELINE	Middle OAKES	Last JANUARY
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 31, 1897
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) 69 yrs.
13. FATHER'S NAME Karren		11. BIRTHPLACE (County & State, or foreign country) VIRGINIA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 215-32-6634	17. INFORMANT Address Alden W. Oakes - Same as # 2
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Institutional obstruction		INTERVAL BETWEEN ONSET AND DEATH	
578X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized peritonitis, septicemia, (c) Small bowel fistula.		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec. 28, 1966 , to Jan. 8, 1967 , that (I) (we) last saw the deceased alive on Jan. 7, 1967 , and that death occurred at 12:10 AM , from causes and on the date stated above.		22b. DATE SIGNED 1, 8, 67	
22a. SIGNATURE See o lant		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS
22c. PHYSICIAN'S NAME (Type) ARSENIO - Santos			
23a. BURIAL, CREMATION, BURIAL REMOVAL (Specify) Burial		23b. DATE THEREOF 1/11/67	23c. NAME OF CEMETERY OR CREMATORIAL Glen Haven Memorial Pk.
24. FUNERAL DIRECTOR Robert L. Ware Singleton Funeral Home		ADDRESS Glen Burnie, Md.	23d. LOCATION (City or Town) (County) (State) Glen Burnie, Md.
		25a. REC'D BY REGISTRAR DATE JAN 11 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00157

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00159

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General		d. STREET ADDRESS Rte. 5 Box 30	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Gertrude		First Owens	Middle L
4. DATE OF DEATH Month 1	Day 10	Year 1967	
S. SEX female	6. COLOR OR RACE colored	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH 12/12/1926	9. AGE (In years last birthday) 40 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Annapolis, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Edward Little		
14. MOTHER'S MAIDEN NAME Seasette Johnson	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) If yes give war or dates of service) No	16. SOCIAL SECURITY NO.	17. INFORMANT George C. Owens - Anna, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fatty alteration of liver			INTERVAL BETWEEN ONSET AND DEATH
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Werner U. Spitz</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 1/10/67
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.	23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		
23b. DATE THEREOF 1/14/67	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Broadneck		23d. LOCATION (City or Town) (County) (State) St. Margaret's, Md.
24. FUNERAL DIRECTOR William Reese, Jr. - Anna, Md.	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge	
VR A15ME (5) 6M 1/66	DATE Jan 11 1967		

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1940-1950'S STYLING & TRENDS

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1950's

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

M

00158

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00160

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1and2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gibson Island		b. COUNTY Anne Arundel	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gibson Island	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Barn - Cumberstone & R. 468		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HENRY L. PARKER		First	Middle
4. DATE OF DEATH Month 1	Month 4	Day 19	Year 67
S. SEX Male	6. COLOR OR RACE Negro	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday) 23 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: Near Contact Shotgun Wound of Chest			
IMMEDIATE CAUSE (a) 976X			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) {			
DUE TO			
(c) }			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot Self in Chest			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 8:00 1 4 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Barn		20f. (City or town) (County) (State) Anne Arundel Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Petty		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
Address (Street, city, town, or county) 11-12-67			
22. DATE SIGNED 1/5/67			
23a. BURIAL, CREMATION, REMOVAL (Specify) 11-12-67		23b. DATE THEREOF 11-12-67	
23c. NAME OF CEMETERY OR CREMATORIAL Bellevue Med. School		23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR Charles S. Petty		25a. REC'D BY REGISTRAR Charles S. Petty	
ADDRESS 11-12-67		25b. REGISTRAR'S SIGNATURE Charles S. Petty	
DATE JAN 13 1967			

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FOR STATE
HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00161

00159

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Beach Drive, Selby Bay		d. STREET ADDRESS Beach Drive, Selby Bay		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WALTER		Middle F.	Lost PARRISH	Month January	Doy Year 23 19 67
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-28-1929	9. AGE (In years last birthday) 88 37 yrs.
10e. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) Meat Cutter Retail		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Alabama USA	
13. FATHER'S NAME James A. Parrish		14. MOTHER'S MAIDEN NAME Jean Williams		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or Unknown) Yes Wife		16. SOCIAL SECURITY NO. 421-30-3403		17. INFORMANT Mary Louise Parrish #2	
IB. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Carbon Monoxide Intoxication and Massive Body Burns. X X X X X Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Conflagration		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour XX p.m. 1/23 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Edgewater	(County) (State) A.A. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspectian <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Charles S. Petty</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) Charles S. Petty			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-27-67	23c. NAME OF CEMETERY OR CREMATORIUM Arlington National Cemetery	23d. LOCATION (City or Town) Arlington	(County) (State) Virginia
24. FUNERAL DIRECTOR John M. Taylor & Sons Crematories, Inc.		ADDRESS 1101 N. Glebe Rd., Arlington, VA 22201	25a. REG'D. BY REGISTRAR JAN 30 1967	25b. REGISTRAR'S SIGNATURE Charles S. Petty	DATE
VR A15ME (5) 6M 1/67					

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00160

CERTIFICATE OF DEATH

00162

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY AA				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN lb 3 days				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		Severn				
3. NAME OF DECEASED (Type or print) Charles S		4. DATE OF DEATH Lost Patrick Month January Doy 27 Year 1967				
S. SEX M	6. COLOR OR RACE W	7. MARRIED X NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 7-30-87 7/30/86 9. AGE (In years lost birthday) 80 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer		10b. KIND OF BUSINESS OR INDUSTRY Ret. Farmer				
11. BIRTHPLACE (County & State or foreign country) Russell Co. - Virginia		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME James R. Patrick		14. MOTHER'S MAIDEN NAME Sally Hess				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 227-05-9797				
17. INFORMANT Mrs. Paul E. Bonovich, Gettysburg, Pa. R-1		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. 14231		Congestive heart failure 4. S. C. V. D. INTERVAL BETWEEN ONSET AND DEATH 1 week				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from Sept 15, 1966 to Jan 27, 1967, that (I) (we) last saw the deceased alive on Sept 15, 1967, and that death occurred at 7:30 PM, from causes and on the date stated above.		22b. DATE SIGNED 1-27-67				
22a. SIGNATURE Robert Dabrowski		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) ROBERT DABROWSKI, MD		22d. ADDRESS 400 CRDN HWY NW Glen Burnie, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/31/67	23c. NAME OF CEMETERY OR CREMATORIAL Bel Air Memorial Gardens	23d. LOCATION (City or Town) Bel Air, Harford Co., Md.	(County)	(State)
24. FUNERAL DIRECTOR Richard A. Little		ADDRESS Littlestown, Pa.	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge	DATE JAN 30 1967	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH			00163		
1. PLACE OF DEATH a. COUNTY			Anne Arundel			MARYLAND			2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)			a. STATE Maryland			b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Annapolis			c. LENGTH OF STAY IN 1b over 30 yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Annapolis			d. STREET ADDRESS 72 Clay Street		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			72 Clay Street						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)			First THOMAS NMN			Middle PERRY			4. DATE OF DEATH Jan. 5			Month 1967			Day Year		
5. SEX Male			6. COLOR OR RACE Negro			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH Jan. 3-1894			9. AGE (In years last birthday) 73 yrs.			IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			Construction Laborer			10b. KIND OF BUSINESS OR INDUSTRY Retired			11. BIRTHPLACE (County & State, or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY U.S.A.					
13. FATHER'S NAME Unknown						14. MOTHER'S MAIDEN NAME Unknown											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)			No			16. SOCIAL SECURITY NO. 214-05-1822			17. INFORMANT Anna Belle Johnson-111 Obery Crt. Annapolis, Maryland			Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			153.3			CARCINOMA, SIGMOID COLON, WITH METASTASES TO LUNGS AND ABDOMINAL VISCERA						AT LEAST 2 1/2 YEARS					
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.			(b)			DUE TO											
			(c)			DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> ND <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) Annapolis			(County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 8-15, 1964, to 1-5-, 1967, that (I) (we) last saw the deceased alive on 1/2-22, 1964, and that death occurred at 1/2-14 M, from the causes and on the date stated above.																	
22a. SIGNATURE A.L.Kison									M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 1/2-14					
22c. PHYSICIAN'S NAME (Type)			A.L.KISON			22d. ADDRESS 1407 Forrest Drive Annapolis, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Jan. 9-67			23c. NAME OF CEMETERY OR CREMATORIAL Brewer Hill			23d. LOCATION (City, town or county) Annapolis, Maryland			(State)					
24. FUNERAL DIRECTOR C.E.Hicks 111 Annapolis, Md.			ADDRESS						25a. REC'D BY REGISTRAR DATE JAN 11 1967			25b. REGISTRAR'S SIGNATURE Charles Judge					
VR A15 (4) 2DM 1/65																	

Albuquerque, NM, USA

22. 1 **10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 13, 14 Film G585 2/14/67 mh

00162

CERTIFICATE OF DEATH

00164

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE		c. LENGTH OF STAY IN lb 1 month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NORTH ARUNDEL HOSPITAL				d. STREET ADDRESS 117 CRAIN HWY. N.E.			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILBUR Middle C. Last PHELPS		4. DATE OF DEATH JANUARY 23 Day 1977					
S. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 16-93	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - BAR OWNER		10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (County & State, or foreign country) BROOKLYN, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Rufus D. (Unknown) Phelps		14. MOTHER'S MAIDEN NAME (Unknown) Mollie Cromwell					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) W.W.I Yes		16. SOCIAL SECURITY NO. 216-28-9924		17. INFORMANT Mrs Ruth M. Phelps (Wife)		Address Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 197.9 DUE TO ACUTE GASTRIC DILATATION INTERVAL BETWEEN ONSET AND DEATH SEVERAL MINUTES							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO GENERALIZED CARCINOMATOSIS 3 MOS.							
(c) DUE TO RHABDOMYOSARCOMA 1 YR.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-5-66, 19, to 1-23-67, 19, that (I) (we) last saw the deceased alive on 1-23-67, 19, and that death occurred at 1:10 p.m., from causes and on the date stated above.							
22a. SIGNATURE Maurice J. Berman				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) MAURICE J. BERMAN, M.D.				22d. ADDRESS 614 MEDICAL ARTS BDLG. BALT., MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 26, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore Nat'l Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Richard V. Singleton Glen Burnie, Md.				ADDRESS		25a. RECD BY REGISTRAR	25b. REGISTRAR'S SIGNATURE Charles J. ...
DATE JAN 26 1967							

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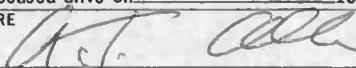
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00163 CERTIFICATE OF DEATH **00165**

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 208 Eastern Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ROBERT	Middle EDWARD	Last PINDELL Jr.
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 22-1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Laborer - retired		10b. KIND OF BUSINESS OR INDUSTRY A.A.Co. Maryland	
13. FATHER'S NAME Robert E. Pindell Sr.		14. MOTHER'S MAIDEN NAME Carrie ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-05-1880 A	
17. INFORMANT Birdie H. Pindell-208 Eastern Ave. Annapolis, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO (b) metastasis to vital organs (c) OUE TD PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cathedral St. Annapolis, Md.
20f. (City or town) Annapolis (County) Md. (State) Md.		21. I certify that (I) (this hospital) attended the deceased from 19 , to 19 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at M. from the causes and on the date stated above.	
22a. SIGNATURE 		22b. DATE SIGNED JAN 17 1967	
22c. PHYSICIAN'S NAME (Type) A.T. Allen		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Cathedral St. Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 14-67	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Pine Lawn		23d. LOCATION (City, town or county) (State) Bestgate Rd. Annapolis, Md.	
24. FUNERAL DIRECTOR C.E.Hicks III Annapolis, Maryland		25a. REC'D BY REGISTRAR Charles Judge 25b. REGISTRAR'S SIGNATURE	
		DATE JAN 17 1967	

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Биофарм, г. Краснодар, КБК 401010000

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00164

CERTIFICATE OF DEATH

00165

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Anne Arundel Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Md. b. COUNTY A.A.Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN lb 15 Days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hosp.		d. STREET ADDRESS Hospital Dr., Glen Burnie, Md.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Robert	Middle E.	Last Ravel Sr.		
4. DATE OF DEATH	Month Jan.	Day 28	Year 1967		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/17/1900	9. AGE (In years lost birthday) yrs. 66 8 11	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Shipbuilding		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.	
13. FATHER'S NAME Joseph Ravel		14. MOTHER'S MAIDEN NAME Ward		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 218-03-7885		17. INFORMANT Margaret Ravel (Wife) As Above Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 181.0 DUE TO <i>Tremor ad</i>				INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>Carcinoma Bladder.</i> (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Brooklyn	(County) A. A. Md. (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at _____ M, from causes and on the date stated above					
22a. SIGNATURE <i>R. L. Fink</i>		M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) <i>R. L. Fink</i>		22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/31/1967	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery	23d. LOCATION (City or Town) Brooklyn	(County) A. A. Md. (State)
24. FUNERAL DIRECTOR Raymond C. Fink		ADDRESS Glen Burnie, Md.		25a. REC'D BY REGISTRAR JAN 31 1967	25b. REGISTRAR SIGNATURE <i>Charles Judge</i>

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00165

CERTIFICATE OF DEATH

00167

Item o Film G385 1/25/67 mb

1. PLACE OF DEATH

a. COUNTY

Anne Arundel

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

North Linthicum

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

10 Hampton Road

3. NAME OF DECEASED
(Type or print)First
HildaMiddle
C.Last
Reynolds4. DATE
OF
DEATHMonth
JanuaryDay
18,Year
1967

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

1898

68

9. AGE (In years
last birthday)

yrs.

10. IF UNDER 1 YEAR

11. IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Christopher C. Barnsley

14. MOTHER'S MAIDEN NAME

Mary Anderson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Miss Edna Reynolds

Address

same address as above

18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

600.0

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

Aremia

DUE TO

(c)

Chronic Pyelonephritis

INTERVAL BETWEEN
ONSET AND DEATH1 year
several yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Month, Day, Year
Hour e.m.
p.m. 1920d. INJURY OCCURRED
While at work Not While at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from March 1966 to Jan 1967, that (I) (we) last saw the deceased alive on Jan 1967, and that death occurred at 5 P.M. from the causes and on the date stated above.

22a. SIGNATURE

W. K. Gallagher, Jr., M.D.

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

W. K. Gallagher, Jr., M.D.

22d. ADDRESS

6630 Baltimore National Pike. Balto. 21228

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE THEREOF

1/21/1967

23c. NAME OF CEMETERY OR CREMATORI

Loudon Park Cemetery

23d. LOCATION (City, town or county)

Baltimore, Maryland

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

Wm. J. Thibault & Sons

ADDRESS

Balto. Md. DATE JAN 20 1967

25e. REC'D BY REGISTRAR

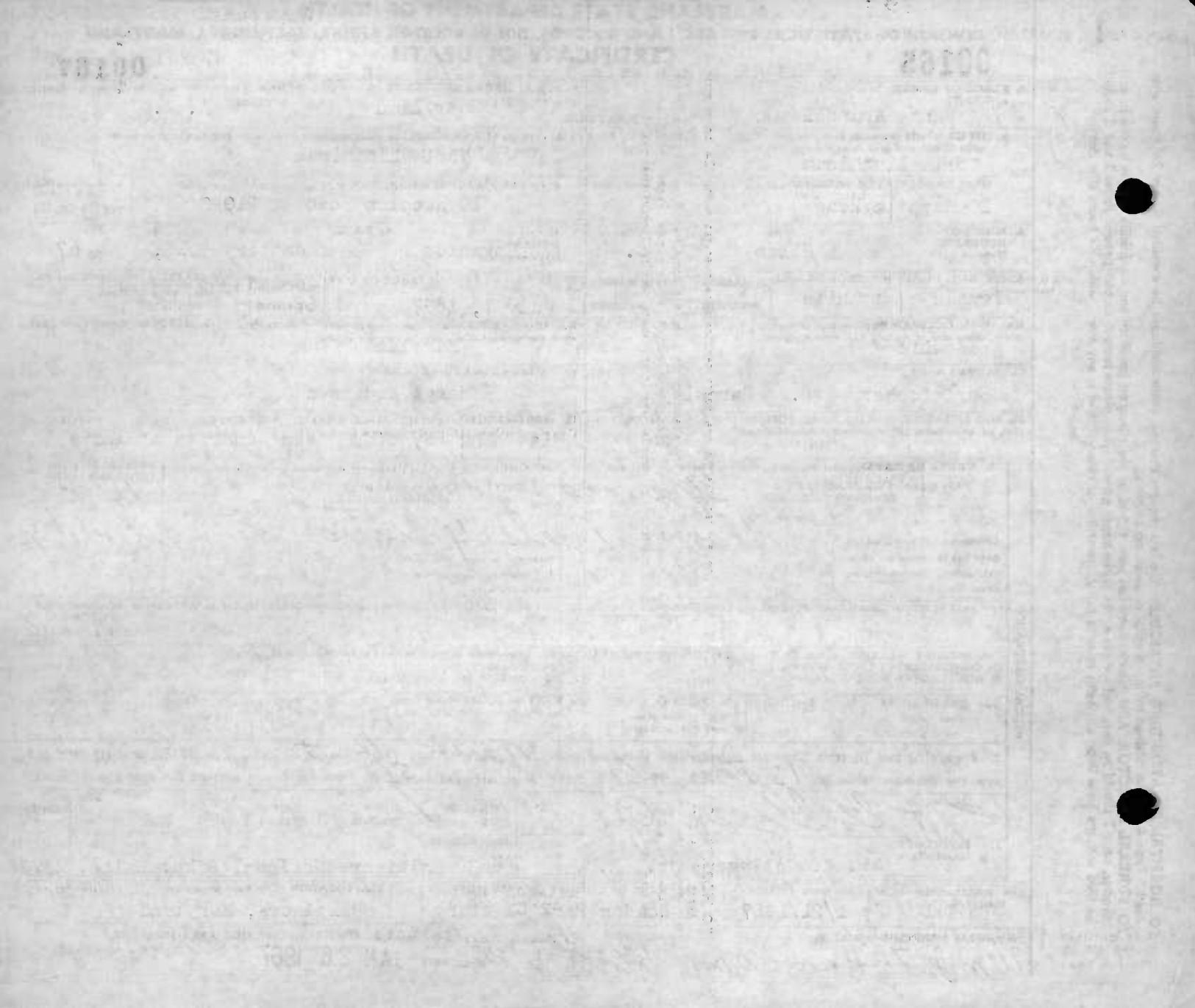
25b. REGISTRAR'S SIGNATURE

Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ISM 7-62



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

00166

CERTIFICATE OF DEATH

00168

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 4 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) #33254 First Norman Middle I.		Last Rice	4. DATE OF DEATH Month 1 Day 9 Year 1967
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 10/18/93
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oyster Business		9. AGE (In years last birthday) 73 yrs.	
13. FATHER'S NAME Charles Rice		11. BIRTHPLACE (County & State, or foreign country) Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		12. CITIZEN OF WHAT COUNTRY? USA	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia INTERVAL BETWEEN ONSET AND DEATH 491X DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), (b) _____ stating the underlying cause lost. (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Brain Syndrome sec. Arteriosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. pm. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____
21. I certify that (I) (this hospital) attended the deceased from 9/91 , 19 66 , to 1/91 , 19 67 , that (I) (we) last saw the deceased alive on 1/91 , 19 67 , and that death occurred at 10:PM , from causes and on the date stated above.		22b. DATE SIGNED 1/10/67	
22a. SIGNATURE <i>W. Benedict, M.D.</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS Crownsville State Hospital, Md.
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-12-67	23c. NAME OF CEMETERY OR CREMATORIAL St George M.E. Church
24. FUNERAL DIRECTOR W. Clarke Mattingly, Leonardtown Md.		23d. LOCATION (City or Town) (County) (State) St George Island Md.	
		25a. REC'D BY REGISTRAR JAN 11 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00167

CERTIFICATE OF DEATH

00169

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>A.A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>MILKERSVILLE</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis, MD. 221</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Kwockwood Nursing Home</i>		d. STREET ADDRESS <i>600 Burnside St.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Henry</i>	Middle <i>Nelson</i>	Last <i>ROANE, Sr.</i>
4. DATE OF DEATH Month <i>1</i> Doy <i>10</i> Year <i>1967</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Jan. 25, 1882</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LUMBER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>HARDWARE</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>CASH, Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Henry H. Roane</i>		14. MOTHER'S MAIDEN NAME <i>MARINETTA GRAY</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>Address</i>	
17. INFORMANT <i>H. NELSON ROANE JR. #2</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> DUE TO <i>420.1</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary artery occlusion few hours</i> DUE TO			
(c) <i>Arteriosclerotic Cardiovascular disease</i>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <i>BALTO</i> (County) <i>Maryland</i> (State) <i>MD.</i>
21. I certify that (I) <i>Ray M. Smith</i> attended the deceased from <i>19</i> , 19 <i>67</i> , to <i>19</i> , 19 <i>67</i> , that (I) <i>Ray M. Smith</i> last saw the deceased alive on <i>19</i> , 19 <i>67</i> , and that death occurred at <i>M</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Ray M. Smith</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>1-11-67</i>
22c. PHYSICIAN'S NAME (Type) <i>Ray M. Smith, M.D.</i>		22d. ADDRESS <i>Hahn ProfBldg., Severna Park, Md.</i>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>1-12-67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Woodlawn</i>	23d. LOCATION (City or Town) <i>BALTO</i> (County) <i>Maryland</i> (State) <i>MD.</i>
24. FUNERAL DIRECTOR <i>John M. Taylor & Sons Annapolis, Md.</i>	ADDRESS	25a. REC'D BY REGISTRAR <i>JAN 10 1967</i>	25b. REGISTRAR'S SIGNATURE <i>John M. Taylor & Sons Annapolis, Md.</i>

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DATE 10-10-68 BY SP-100

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00168

CERTIFICATE OF DEATH

00170

1. PLACE OF DEATH a. COUNTY <i>A.A.Co.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>A.A.Co.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>WEEMS CREEK</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>WEEMS CREEK</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>105 Wilson Road</i>				d. STREET ADDRESS <i>105 Wilson Road</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First <i>MAUD</i>	Middle <i>E.</i>	Last <i>Rogers</i>	4. DATE OF DEATH	Month <i>1</i>	Day <i>21</i>	Year <i>1967</i>
S. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>11-16-1878</i>	9. AGE (In years less birthday) <i>88</i> yrs.	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>House Wife</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Arlington MD.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.</i>	
13. FATHER'S NAME <i>Calvin O. Ditch</i>		14. MOTHER'S MAIDEN NAME <i>HARRIETT Moore</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mildred R. Myers #2</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO (b) <i>Coronary Thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Arteriosclerotic Heart Disease</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>June</i> , 19 <i>67</i> , to <i>July 1, 1967</i> , that (I) (we) last saw the deceased alive on <i>15 July 1967</i> , and that death occurred at <i>1039</i> M, from causes and on the date stated above.							
22a. SIGNATURE <i>Edward S. Beck</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>1-23-67</i>			
22c. PHYSICIAN'S NAME (Type) <i>EDWARD S. BECK</i>		22d. ADDRESS <i>75 Franklin St. Annapolis, MD.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1-24-67</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>LORRAINE CEMT.</i>		23d. LOCATION (City or Town) (County) (State) <i>BALTO MD.</i>	
24. FUNERAL DIRECTOR <i>John M. Taylor Sons Annapolis Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR DATE <i>JAN 24 1967</i>		25b. REGISTRAR'S SIGNATURE <i>John M. Taylor Sons Annapolis Md.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0109

NAME TO FINGER

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00169

CERTIFICATE OF DEATH

00171

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN lb 11mos. 15das.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) #31153		First James	Middle Roundtree
4. DATE OF DEATH Month 1		5. DATE OF BIRTH Month 2 Day 5 Year 1896	6. AGE (In years last birthday) Yrs. 70
S. SEX Male	7. COLOR OR RACE Negro	8. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Radio Tech. (ref.)		10b. KIND OF BUSINESS OR INDUSTRY -----	10c. BIRTHPLACE (County & State, or foreign country) North Carolina
13. FATHER'S NAME Martin Roundtree		14. MOTHER'S MAIDEN NAME Nancy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Hospital Records
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebrovascular Accident DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Brain Syndrome - Inanition and Diabetes Mellitus			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour o.m. ----- 19 -----		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1/20/1966 , to 1/5/1967 , that (I) (we) last saw the deceased alive on 1/5/1967 , and that death occurred at 1:30 M, from causes and on the date stated above.			
22a. SIGNATURE <i>L. Benedict</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 1/5/67
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.		22d. ADDRESS Crownsville State Hospital, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 1-26-67	23c. NAME OF CEMETERY OR CREMATORIAL Ud. Med. School
24. FUNERAL DIRECTOR Williams Reese Jr.		ADDRESS 108 W. W. St. #1	25a. REC'D BY REGISTRAR DATE JAN 27 1967
			25b. REGISTRAR'S SIGNATURE <i>Charles J. Jagger</i>

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SEARCHES

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00170

CERTIFICATE OF DEATH

00172

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>129 Conduit St.</i>		d. STREET ADDRESS <i>129 Conduit St.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>JANET L. SABALOT</i>		4. DATE OF DEATH Month <i>1</i>	Day Year <i>7 1967</i>
S. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-18-1897</i>
9. AGE (In years last birthday) yrs. <i>69</i>		10. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>ALFRED BAGBY JR.</i>		14. MOTHER'S MAIDEN NAME <i>JANET CAMPBELL</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>ABEL C. J. SABALOT</i>	
17. INFORMANT Address <i>Address</i>		18. CAUSE OF DEATH (Enter only one cause per line for (g), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i>	
DUE TO (b) <i>Atherosclerotic Heart Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>unknown</i>	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>38 Cornhill Annapolis Md.</i>
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>2-12-</i> , 19 <i>65</i> , to <i>T-22</i> , 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>July 2nd, 1965</i> , and that death occurred at <i>38 Cornhill Annapolis Md.</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>W. Stephens</i>		22b. DATE SIGNED <i>9 Jan. 1967</i>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1-18-67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>U.S. Naval Academy</i>
23d. LOCATION (City or Town) (County) (State) <i>Annapolis, Md. Md.</i>		23e. REC'D BY REGISTRAR	
24. FUNERAL DIRECTOR <i>John M. Stephens Annapolis, Md.</i>		25b. REGISTRAR'S SIGNATURE DATE JAN 12 1967 <i>Charles Judge</i>	

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit, then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 2 Film G385 1/24/67 mh

CERTIFICATE OF DEATH

00173

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Myrtle Street N. Linthicum		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 24 Old Annapolis Rd. Kingspring Wood Nursing Home		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. DATE OF DEATH January 4 1967		
3. NAME OF DECEASED (Type or print)	First Ethel	Middle W.	4. DATE OF DEATH January 4 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH January 17, 1880	
9. AGE (In years last birthday) 86 yrs.	10. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (County & State, or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John West	14. MOTHER'S MAIDEN NAME Sadie Bundick	Address		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Nancy Keesey - 24 Old Annapolis Rd.	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial infarction DUE TO (c) Arteriosclerosis, general & coronary DUE TO INTERVAL BETWEEN ONSET AND DEATH 4 months	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic nephrosclerosis with uremia, esophageal stricture, bronchopneumonia, pleural effusion	21. I certify that (I) (this hospital) attended the deceased from 13 December 1966 , to 4 January 1967 , that (I) (we) last saw the deceased alive on 4 January 1967 , and that death occurred at 4:20 P.M. M, from causes and on the date stated above.		
22. MEDICAL CERTIFICATION	20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
22b. DATE SIGNED 5 January 1967	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	21. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. PHYSICIAN'S NAME (Type) Charles W. Kinzer, M. D.	22d. ADDRESS South River Medical Center Edgewater, Maryland 21037
23. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan. 7, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Wachapreague Cemetery	23d. LOCATION (City or town) (County) (State) Accomac Co. Va.	
24. FUNERAL DIRECTOR George J. Gonce-4001 Ritchie Hwy., Baltimore,	ADDRESS M.	25a. REC'D BY REGISTRAR JAN 9 1967	25b. REGISTRAR'S SIGNATURE Charles Judge	

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presented evidence

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returning tomorrow

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in case I have to leave

considering you're still in town, I'm going to go back to the office

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considering you're still in town, I'm going to go back to the office

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00172

CERTIFICATE OF DEATH

00174

1. PLACE OF DEATH

a. COUNTY

ANNE ARUNDEL

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

ANNAPOLIS, MARYLAND

c. LENGTH OF STAY IN lb

7 hr.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

ANNE ARUNDEL GENERAL HOSPITAL

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATHMonth
1Day
7Year
1967

5. SEX

FEMALE

6. COLOR OR RACE

NEGRO

7. MARRIED

 NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

6-9-20

9. AGE (In years
last birthday)

46

IF UNDER 1 YEAR
Months DaysIF UNDER 24 HRS.
Hours Min.10e. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

PRESSER

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

HORACE PACK

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

LOIS V. SHARPS

TAKOMA PARK, MD.

14. MOTHER'S MAIDEN NAME

Arkansas

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

443X

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

Subarachnoid hemorrhage 8 hrs.
Anticoagulant C.V. disease Hypertension yrs.INTERVAL BETWEEN
ONSET AND DEATH

8 hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.20d. INJURY OCCURRED
While at work Not While at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)20f. (City or town)
(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Jan 6, 1967 to Jan 7, 1967, that (I) (we) last
saw the deceased alive on Jan 7, 1967, and that death occurred at 255 M, from the causes and on the date stated above.

22a. SIGNATURE

Mannie Klawans,

M.D.

22b. DATE
SIGNED22c. PHYSICIAN'S
NAME (Type)

MANNIE K. KLAWANS

ATTENDING
PHYS. MED.
DIRECTOR STAFF
PHYS. 23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial 1-9-1967

23b. DATE THEREOF

Brewer Hill Annapolis Md

23c. NAME OF CEMETERY OR CREMATORIAL

315 SOUTHGATE AV, ANNAPOLIS, MD

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

William Reeset Anna Md

ADDRESS

25a. REC'D BY REGISTRAR JAN 10 1967

25b. REGISTRAR'S SIGNATURE Charles Judge

DATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

ST100

10 DEC 73 STADLER

ST100

Wet sandstone
No shales

Chert
X - 6
Siltstone
Kyanite

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00173

CERTIFICATE OF DEATH

00175

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician. Please sign and completely fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>A.A. Co.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD.</i>		b. COUNTY <i>A.A. Co.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SEVERNA PARK</i>		d. STREET ADDRESS <i>4 OLD Opposition Road</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Annapolis Nursing Home</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>GEORGE SHEPHERD</i>		First <i>G.</i>	Middle <i>H.</i>	Last <i>SHEPHERD</i>	4. DATE OF DEATH Month <i>1</i>	Day <i>19</i>	Year <i>1967</i>
S. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>1-5-1883</i>	9. AGE (In years last birthday) <i>82</i> yrs.	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HARDWARE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>MERCHANT</i>		11. BIRTHPLACE (County & State, or foreign country) <i>N.JERSEY</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>EDWARD SHEPHERD</i>		14. MOTHER'S MAIDEN NAME <i>EMMA Hoppock</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>EDWARD SHEPHERD #2</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH <i>4 yrs</i>					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i>		DUE TO <i>Cerebrovascular Endocrinopathy disease</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>last.</i>		DUE TO (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <i>1/15/67</i> to <i>1/15/67</i> , that (I) (we) last death occurred at <i>6:30A.M.</i> from causes and on the date stated above.							
22o. SIGNATURE <i>Richard A. Bullock</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>R.N. PEEHER</i>		22d. ADDRESS <i>CATHEDRAL ST. ANNAPOLIS, MD.</i>		22e. DATE SIGNED <i>1/15/67</i>			
23a. BURIAL/CREMATION, REMOVAL SPECIAL? <i>BURIAL</i>		23b. DATE THEREOF <i>1-21-67</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>DORCHESTER MEMORIAL CAMBRIDGE</i>		23d. LOCATION (City or Town) (County) (State) <i>MD.</i>	
24. FUNERAL DIRECTOR <i>John M. Lynch & Sons Annapolis, Md.</i>		ADDRESS		25a. REC'D. BY REGISTRAR DATE <i>JAN 24 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00174

CERTIFICATE OF DEATH

00176

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas Edward SHERLOCK		First Middle Last	4. DATE OF DEATH January 8 1967
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH March 27, 1891		9. AGE (In years last birthday) 75 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ref.		10b. KIND OF BUSINESS OR INDUSTRY CIVIL SERVICE	
11. BIRTHPLACE (County & State, or foreign country) ANNAPOLIS, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME THOMAS E. SHERLOCK SR.		14. MOTHER'S MAIDEN NAME Emily TUCKER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES WWI		16. SOCIAL SECURITY NO.	
17. INFORMANT HELEN OLSEN #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Artemisinosis</u> DUE TO <u>Artemisinosis</u> /work (c) <u>Artemisinosis & glomerulonephritis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) diabetes mellitus			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at 8:15 p.m. from causes and on the date stated above.			
22a. SIGNATURE <i>Dr. Smith</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 1-9-67
22c. PHYSICIAN'S NAME (Type) Ray M. Smith, M.D.		22d. ADDRESS Hahn ProfBldg., Severna Park, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-11-67	23c. NAME OF CEMETERY OR CREMATORIAL CEDAR Bluff
24. FUNERAL DIRECTOR John M. Taylor Sons Annapolis, Md.		ADDRESS	23d. LOCATION (City or Town) Annapolis (County) MD- 25. REC'D BY REGISTRAR DATE JAN 12 1967
26. REGISTRAR'S SIGNATURE Charles Judge			

27100

— 1 —

Leptoglossus A.

1-11-12 CEDAR SPRINGS

AM (segment 2) 15 words

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00175

CERTIFICATE OF DEATH

00177

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician. Then please file in carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville		c. LENGTH OF STAY IN lb 7 Mos.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Knollwood Nursing Home, Millersville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Sadie	Middle (nmi)	Last Shriver(Schrieber)
4. DATE OF DEATH Month January	Month 23	Doy 19	Year 67
5. SEX F.	6. COLOR OR RACE Cau.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIOOWEO <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 24, 1882
9. AGE (In years lost birthday) 84 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife (Ret)	11. KIND OF BUSINESS OR INDUSTRY Own Home	12. BIRTHPLACE (County & State, or foreign country) Delaware
13. FATHER'S NAME Thomas Aaron	14. MOTHER'S MAIDEN NAME Mary E. Mc Graw	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None	
16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Mrs. Lottie J. Hoyt (daughter)	Address Rt. 11-Box 82 Pasadena	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Central thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterioclotic Cardiovascular disease 3 days DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia and congestive heart failure			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hahn Professional Bldg., Severna Pk., Md
21. I certify that (I) (this hospital) attended the deceased from April 3, 1965 , to Jan. 23, 1967 , thot (I) (we) last saw the deceased alive on Oct. 8, 1966 , and thot death occurred at 11:00 AM , from causes and on the date stoted above.		22b. DATE SIGNED JAN 26 1967	
22a. SIGNATURE Ray M. Smith, M. D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS Hahn Professional Bldg., Severna Pk., Md
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 25, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery
24. FUNERAL DIRECTOR Richard V. Singleton		ADDRESS Glen Burnie, Md.	25a. REC'D BY REGISTRAR Charles Judge
		DATE JAN 26 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

ST100

DATA IN PAGES

ST100

CERTIFICATE OF DEATH

03090

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4 may be retained by the hospital or attending physician.						TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.							
1. PLACE OF DEATH a. COUNTY Anne Arundel			MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Maryland			30-519				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville			c. LENGTH OF STAY IN lb 3yrs. 8mos.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			92-4				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital						d. STREET ADDRESS 1624 Barnes Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) #25200			First Edward	Middle J.	Last Small	4. DATE OF DEATH 1 20 19 67			Month Day Year				
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED WIDOWED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 5/12/99		9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cement Finisher			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) South Carolina			12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Joseph Small						14. MOTHER'S MAIDEN NAME Hattie							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. None			17. INFORMANT Hospital Records			Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <u>4321</u> DUE TO Pulmonary Embolism? INTERVAL BETWEEN ONSET AND DEATH													
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) DUE TO Arteriosclerotic Cardio-Vascular Disease (c) DUE TO / Xanthomatous Lesions, Xanthomas, Xanthelasma													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Brain Syndrome; Azotomia													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) -----									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. ----- p.m. -----			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 4/23/1963 to 1/20/1967 that (I) (we) last saw the deceased alive on 1/20/1967, and that death occurred at 9:25 A.M. from causes and on the date stated above.													
22a. SIGNATURE <u>Wm. Benedict, M.D.</u>												22b. DATE SIGNED 1/23/67	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.			22d. ADDRESS Crownsville State Hospital, Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify) <input checked="" type="checkbox"/>			23b. DATE THEREOF 3/6/67			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Woodlawn Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.				
24. FUNERAL DIRECTOR William Rees II 108 W. Washington St.			ADDRESS Annapolis			25a. REC'D BY REGISTRAR DATE MAR 7 1967			25b. REGISTRAR'S SIGNATURE Charles Judge				

9-080

1947 TO STANDBY

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1947

STANDBY

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00176

CERTIFICATE OF DEATH

00178

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	c. LENGTH OF STAY IN lb 2 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 16 Disney Ave.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles Armond SMITH	First Charles	Middle Armond	Last SMITH
4. DATE OF DEATH January 11 1967	Month January	Doy 11	Year 1967
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH Oct. 3, 1894	9. AGE (In years last birthday) 72 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur	10b. KIND OF BUSINESS OR INDUSTRY Produce	11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME John Lowe Smith		14. MOTHER'S MAIDEN NAME Laura Virgie Scheminant	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	16. SOCIAL SECURITY NO. 215-03-8243	17. INFORMANT Mrs. Gloria Taylor - 16 Disney Ave., Pasadena, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO 420.0		INTERVAL BETWEEN ONSET AND DEATH 12 hours	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Malignant Hypertension DUE TO Arteriosclerotic Heart Disease		2 yrs. 8 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (his/her) attended the deceased from 1959 , to Jan. 11 , 1967, that (II) 206 last saw the deceased alive on Jan. 11 , 1967, and that death occurred at M , from causes and on the date stated above.		5:30 AM	
22a. SIGNATURE Arthur Lankford Jr. MD	22b. DATE SIGNED 1-11-67		
22c. PHYSICIAN'S NAME (Type) Arthur Lankford, Jr.	22d. ADDRESS 2934 Mountain Road, Pasadena, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan. 14, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Ritchie Hwy., A.A.C.O., Md.
24. FUNERAL DIRECTOR George J. Gonce-4001 Ritchie Hwy., Baltimore	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE J Charles Juge
		DATE JAN 17 1967	

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Initial

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after

death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00177

CERTIFICATE OF DEATH

00179

1. PLACE OF DEATH
a. COUNTY

Anne Arundel

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Glen Burnie

c. LENGTH OF STAY IN 1b

DOA

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

North Arundel Hospital

3. NAME OF
DECEASED
(Type or print)

First
Edward

Middle
Whayland

Last
Snyder, Jr.

4. DATE
OF
DEATH

January 24, 1967

S. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

B. DATE OF BIRTH

9. AGE (In years
last birthday)

IF UNDER 1 YEAR IF UNDER 24 HRS.

Male

White

WIDOWED

DIVORCED

6. May 1921

45 yrs.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Dispatcher

10b. KIND OF BUSINESS OR INDUSTRY

Coast Tank Lines

11. BIRTHPLACE (County & State, or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Edward W. Snyder, Sr.

Edna E. Ruby

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

Yes

WW 2

218-09-6414

16. SOCIAL SECURITY NO.

17. INFORMANT

Mrs. Dorothy W. Snyder, same as 2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

colony ulcerous disease.

INTERVAL BETWEEN
ONSET AND DEATH

287X
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last. (b)

DUE TO

hypertensive cardio vascular

(c)

obesity

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

3 MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m. 20d. INJURY OCCURRED
p.m. 19 While Not While
at work at work
20e. PLACE OF INJURY (Home, farm
factory, street, office bldg., etc.)
20f. (City or town)
(County) (State)

21. I certify that (I) (this hospital) attended the deceased from

Oct. 1, 1966 to Jan 24, 1967, that (I) (we) last

saw the deceased alive on Jan 24, 1967, and that death occurred at 11 A.M. from the causes and on the date stated above.

22a. SIGNATURE

Philip Keister, M.D.

ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.

22b. DATE SIGNED
25 Jan. 67

22c. PHYSICIAN'S
NAME (Type)

Philip Keister, M.D.

22d. ADDRESS

302 Potapsco Ave., Baltimore, Md.

(State)

23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial 23b. DATE THEREOF
27 Jan. 1967 23c. NAME OF CEMETERY OR CREMATORIUM
Cedar Hill Cemetery

23d. LOCATION (City, town or county) (State)
Baltimore, Md. 21225

24 FUNERAL DIRECTOR'S SIGNATURE

Kirkley Funeral Home, Glen Burnie, Md.

ADDRESS

25a. REC'D. BY REGISTRAR

JAN 30 1967

25b. REGISTRAR'S SIGNATURE

Charles Judge

BT100

100% Cotton

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 8 Film G385 1/25/67 mh

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00180

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00178

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. Maryland		b. COUNTY Anne Arundel				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie, Md.		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie, (Rural)						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital, Glen Burnie, Md.				d. STREET ADDRESS 302 Freetown Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Carlae	Middle Lee	Last Hansen	4. DATE OF DEATH Month 1	Month 18	Doy 19	Year 67		
S. SEX F	6. COLOR OR RACE IV	7. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 8-3-1888	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? U.S.A				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Re		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? U.S.A				
13. FATHER'S NAME James Brown		14. MOTHER'S MAIDEN NAME Mary		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 4344		16. SOCIAL SECURITY NO.		17. INFORMANT Senora Smith 282 Valley Rd		Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer -		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Doy, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) -		(County) -		(State) -
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										22. DATE SIGNED 1-18-67
ACTUAL SIGNATURE E. Hansen		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) E. Hansen		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) St. Louis, Mo.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/23/67		23c. NAME OF CEMETERY OR CREMATORIAL Hills Church Yard		23d. LOCATION (City or Town) St. Louis, Mo.		(County) St. Louis Co., Mo.		(State) Mo.
24. FUNERAL DIRECTOR Ed Brown & Son, 108 W. Montgomery St.		ADDRESS		25a. RECD BY REGISTRAR JAN 20 1967		25b. REGISTRAR'S SIGNATURE Charles Judge				

03-100

03-100

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00181

30181

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
o. COUNTY Anne Arundel		a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 1/16/1967				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Elsa		First (nmi)	Middle Stearn			
Last Stearns		4. DATE OF DEATH January 14	Month Year Doy 67			
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Librarian		10b. KIND OF BUSINESS OR INDUSTRY State of Md.				
13. FATHER'S NAME (unknown)		8. DATE OF BIRTH October 29, 1902				
		9. AGE (In years last birthday) 64 yrs.				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 100-16-4403				
17. INFORMANT Husband		11. BIRTHPLACE (County & State, or foreign country) Germany				
		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4/20/1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		ACUTE Myocardial Infarction				
(b) DUE TO (c)		Hypertensive Cardiovascular Disease				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
22a. SIGNATURE Felix Russell		22b. DATE SIGNED 1/19/67				
22c. PHYSICIAN'S NAME (Type) Felix Russell		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 1113 Colchester Rd Baltimore	23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF Jan. 16, 1967	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Loudon Park Crematory	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Eugene B. Flanagan Singleton Funeral Home		ADDRESS Glen Burnie, Md.		25a. REC'D BY REGISTRAR JAN 18 1967	25b. REGISTRAR'S SIGNATURE James Judge	

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MAILED 15 JULY 1968

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00179

00182

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1.		PLACE OF DEATH a. COUNTY		MARYLAND		2.		USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)		
		Baltimore						a. STATE <i>bld.</i>		
		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b				b. COUNTY <i>AA.</i>		
		<i>Baltimore</i>								
		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						e. IS RESIDENCE ON A FARM?		
		<i>Y-5th Ave.</i>						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3.		NAME OF DECEASED (Type or print)		First <i>Enig</i>	Middle <i>E.</i>	Last <i>Sternick</i>	4.	DATE OF DEATH	Month <i>1 - 6 -</i>	Day <i>1967</i>
5.		SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-1-86</i>	9. AGE (In years last birthday) <i>80 yrs.</i>	10. IF UNDER 1 YEAR <input type="checkbox"/> Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	13. CITIZEN OF WHAT COUNTRY? <i>w. Va.</i>
10a.		USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Yours.</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>w. Va.</i>		12. CITIZEN OF WHAT COUNTRY?		
13.		FATHER'S NAME <i>Levi</i>		14. MOTHER'S MAIDEN NAME <i>Hannah</i>						
15.		WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>157X</i>		17. INFORMANT <i>Family - Same</i>		Address <i>Pardee of Pardee w/ metastases</i>		
18.		CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i>		
		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>157X</i>								
		Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		DUE TO (b) _____ (c) _____						
		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
		20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>1617 Cross</i>		20f. (City or town) <i>Baltimore</i> (County) <i>Baltimore</i> (State) <i>Maryland</i>		
21.		I certify that (I) (this hospital) attended the deceased from <i>11/29/67</i> , 19, to <i>11/6/67</i> , 19, that (I) (we) last saw the deceased alive on <i>11/5/67</i> , 19, and that death occurred at <i>11/29/67</i> AM, from the causes and on the date stated above.				22b. DATE SIGNED <i>1/8/68</i>				
22a. SIGNATURE <i>S. Muneses</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS <i>1617 Cross</i>				
22c. PHYSICIAN'S NAME (Type) <i>Silviano B. Muneses</i>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>- 9 - 67</i>		23b. DATE THEREOF <i>11/7 Cross</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Holy Cross</i>		23d. LOCATION (City, town or county) <i>Baltimore</i> (State) <i>Maryland</i>				
24. FUNERAL DIRECTOR <i>McClellan - 237 Fairmount Ave.</i>		ADDRESS				25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
						DATE <i>JAN 9 1967</i>				

28100

40 MAY 1979

ES100

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
00180				00183							
1. PLACE OF DEATH a. COUNTY <i>A.A.C.O.</i> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>GLEN BURNIE</i>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>A.A.</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>N. ARUNDEL Hosp.</i>				d. STREET ADDRESS <i>527 2nd St.</i>							
3. NAME OF DECEASED (Type or print) <i>CARL</i> First <i>F.</i> Middle <i>STEPHAN</i> Last				4. DATE OF DEATH Month <i>1</i> Day <i>18</i> Year <i>1967</i>							
5. SEX <i>M</i> 6. COLOR OR RACE <i>W</i>				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <i>Aug. 8, 1887</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>BARBER</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>BARBER</i>				9. AGE (In years last birthday) <i>79 yrs.</i> IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>			
13. FATHER'S NAME <i>Herman Stephan</i>				11. BIRTHPLACE (State or foreign country) <i>ROSS BACK GERMANY</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>- - -</i>				17. INFDRMANT <i>T. CARL STEPHAN #2</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <i>450.0</i> DUE TO <i>arteriosclerosis generalized</i> Conditions, If any, which gave rise to immediate cause (e), stating the underlying cause first. (b) _____ DUE TO _____ (c) _____											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>stabbed</i>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>p.m.</i> 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>factory</i>			
20f. (City or town) <i>Baltimore</i> (County) <i>M.D.</i> (State) <i>MARYLAND</i>											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>E. L. Barber Jr.</i> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <i>E. L. Barber Jr.</i> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>Annapolis, A.A., MD.</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>				23b. DATE THEREOF <i>1-22-67</i>				23c. NAME OF CEMETERY OR CREMATORIAL <i>HILL CREST</i>			
24. FUNERAL DIRECTOR ADDRESS <i>John M. Vogel Sons Annapolis, Md.</i>				23d. LOCATION (City, town or county) <i>(State)</i> Annapolis, A.A., MD. 25a. REC'D BY REGISTRAR DATE <i>JAN 24 1967</i> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							

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1915-1916

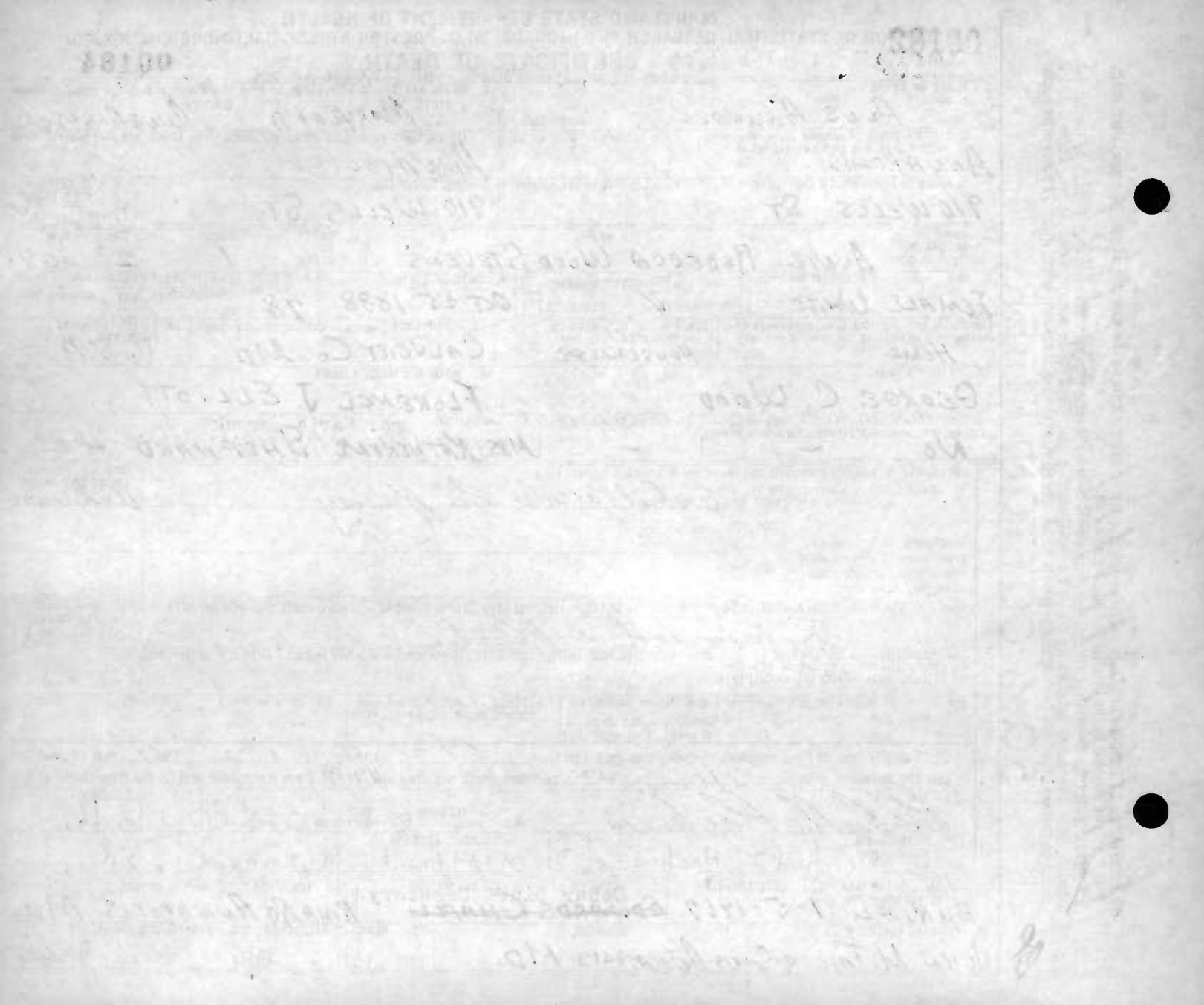
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1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
Item 17 Film #G3841/16/67pc Items 200,230 Film G364 1/9/67 mh CERTIFICATE OF DEATH 00184														
1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)											
Anne Arundel Maryland			a. STATE Maryland b. COUNTY Anne Arundel											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis											
c. LENGTH OF STAY IN 1b			d. STREET ADDRESS 910 Wells St.											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 910 Wells St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) ANNIE REBECCA Wood STEVENS			First	Middle	Last	4. DATE OF DEATH	Month	Day	Year					
5. SEX FEMALE			6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH OCT 25 1888	9. AGE (in years last birthday) 78 yrs.	IF UNDER 1 YEAR <input type="checkbox"/> IF OVER 24 HRS <input type="checkbox"/>	Months	Days	Hours	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home			10b. KIND OF BUSINESS OR INDUSTRY Housewife			11. BIRTHPLACE (County & State, or foreign country) CALVERT Co. MD.			12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME GEORGE C. Wood			14. MOTHER'S MAIDEN NAME FLORENCE J. ELLIOTT											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. -			17. INFORMANT Mrs. Marie Bere Address MRS. MATHER HINKLE / 118 HELPWOOD #2			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 355X Cerebral Vascular Insufficiency DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Rheumatoid arthritis			INTERVAL BETWEEN ONSET AND DEATH Unknown		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Rheumatoid arthritis			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21. I certify that (I) (this hospital) attended the deceased from 6/7, 1967, to 1/2, 1967, that (I) <input type="checkbox"/> last saw the deceased alive on 1/1, 1967, and that death occurred at 11:30 AM, from the causes and on the date stated above.			22a. SIGNATURE Richard I. Hochman			22b. DATE SIGNED 1/3/67								
22c. PHYSICIAN'S NAME (Type) Richard I. Hochman, M.D.			22d. ADDRESS 59 Franklin St., Annapolis, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 1-5-1967			23c. NAME OF CEMETERY OR CREMATORIUM Edwards Chapel			23d. LOCATION (City, town or county) (State) Annapolis MD.					
24. FUNERAL DIRECTOR JOHN M. TAYLOR & SONS Annapolis MD.			ADDRESS			25a. REC'D BY REGISTRAR Charles Judge			25b. REGISTRAR'S SIGNATURE			DATE JAN 5 1967		
VR A15 (4) 20M 1/65														



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00183

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE					
<i>Anne Arundel MARYLAND</i>		b. COUNTY					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b					
<i>Millersville 4 years</i>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<i>Knollwood MANOR</i>							
3. NAME OF DECEASED (Type or print) First Middle Last		4. DATE OF DEATH Month Day Year					
<i>Virginia M. Scilleyan</i>		<i>1-13-67</i>					
5. SEX F		6. COLOR OR RACE W					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-8-1889					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Home					
<i>Housewife</i>		<i>Elkins W. Va</i>					
13. FATHER'S NAME John S. Wright		11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? c.s.					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16. SOCIAL SECURITY NO. 17. INFORMANT Address					
(Yes, no, or unknown) (If yes give war or dates of service)		<i>Mrs Karl Ziegler Above</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450.0</i>							
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.							
DUE TO (b) <i>Pneumonia</i>							
DUE TO (c) <i>Gen- Art Senile</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1960</i> , 19, to <i>1967</i> , 19, that (I) (we) last saw the deceased alive on <i>1-11-67</i> , 19, and that death occurred at <i>8 P.M.</i> from the causes and on the date stated above.				22b. DATE SIGNED <i>1-13-67</i>			
22a. SIGNATURE <i>Robert R. Hahn</i>				22b. DATE SIGNED <i>1-13-67</i>			
22c. PHYSICIAN'S NAME (Type) <i>Robert R. Hahn</i>				22d. ADDRESS <i>P.O. Box 73 Severna Park</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1-18-67</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Hillcrest Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Cumberland, Md</i>	
24. FUNERAL DIRECTOR <i>Robert S. Barranco</i>				25a. REC'D BY REGISTRAR <i>Charles Judge</i> 25b. REGISTRAR'S SIGNATURE			
				DATE JAN 16 1967			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00186

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH e. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
Anne Arundel		e. STATE				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Maryland AA				
Pasadena		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						
Box 141, North Ferry Point Road						
3. NAME OF DECEASED (Type or print)		First	Middle			
William		Joseph Teal				
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH			
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Sept. 13, 1897			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY				
Chauffeur		Retired				
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME				
Frank Teal		Annie Hines				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)		16. SOCIAL SECURITY NO.				
No		17. INFORMANT				
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]		Address				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Nanie L. Teal, same as 2				
527.1 DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 months				
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b)						
} DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)						
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)				
20c. TIME OF INJURY Hour e.m. p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
19						
21. I certify that (I) (this hospital) attended the deceased from..... NOV. 20, 1966, to.... JAN. 13, 1967, that (I) (we) last saw the deceased alive on..... JAN. 13, 1967, and that death occurred at 1030M, from the causes and on the date stated above.				22b. DATE SIGNED 14 Jan. 1967		
22e. SIGNATURE <i>G. Brady Smith</i>		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Brady Smith, M. D.		22d. ADDRESS		Riviera Beach, Pasadena, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 16 Jan. 1967		23c. NAME OF CEMETERY OR CREMATORIAL Western Cemetery		23d. LOCATION (City, town or county) Baltimore, Maryland
24 FUNERAL DIRECTOR'S SIGNATURE Kirkley Funeral Home, Glen Burnie, Md.				ADDRESS		
				25a. REC'D BY REGISTRAR JAN 16 1967		
				25b. REGISTRAR'S SIGNATURE <i>James Judge</i>		

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

00185

CERTIFICATE OF DEATH

00187

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
c. LENGTH OF STAY IN lb		d. STREET ADDRESS 305 Edgemere Drive	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLARK JOSEPH		First CLARK	Middle JOSEPH
4. DATE OF DEATH Month January		Lost TRAYNOR	Year Doy 2 19 67
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. B. DATE OF BIRTH January 1, 1967		9. AGE (In years lost birthday) yrs. IF UNDER 1 YEAR Months 1 Days 1 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SINGLE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME JOSEPH CLARK TRAYNOR		14. MOTHER'S MAIDEN NAME RITA MARIE CONNOR	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT #13 + 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 763.5 Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. Pneumonia		INTERVAL BETWEEN ONSET AND DEATH Respiratory failure	
(b) DUE TO Pneumonia			
(c) DUE TO Pneumonitis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) South River Md.Ctr., Edgewater, Md.
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M. from causes and on the date stated above. 1:30 p.m.		22b. DATE SIGNED 3 Jan 67	
22c. PHYSICIAN'S NAME (Type) Antonio M. Rivera M. D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22d. ADDRESS South River Md.Ctr., Edgewater, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-4-1967	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS HOLLCREST CEM.
23d. LOCATION (City or Town) Annapolis		(County) MD	
24. FUNERAL DIRECTOR John M. Taylor, Sons Annapolis Md.		25a. RECD BY REGISTRAR DATE JAN 5 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00186

CERTIFICATE OF DEATH

00188

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> <u>CROWNSVILLE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROOKLYN</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CROWNSVILLE STATE HOSP.</u>		d. STREET ADDRESS <u>234 EDGEVALE Rd</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>RICHARD</u>		First <u>P.</u>	Middle <u>VOSLER</u>
S. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-11-1892</u>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Serviceman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.A.</u>	9. AGE (In years <u>74</u> to birthday) yrs.
13. FATHER'S NAME <u>THOMAS VOSLER</u>		14. MOTHER'S MAIDEN NAME <u>MARY VOSLER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>WWI and WWII</u>		16. SOCIAL SECURITY NO. <u>214-20-3783</u>	17. INFORMANT Address <u>Mrs. Ethel Vosler-234 Edgevale Rd.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> DUE TO <u>491X</u> Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>CRONIC BRAIN SYNDROME & ARTERIOSCLEROSIS</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>p.m.</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <u>Edgevale</u> (County) <u>Baltimore Co.</u> (State) <u>Md.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>12-26-1966</u> , to <u>1-29-1967</u> that (I) (we) last saw the deceased alive on <u>1-29-1967</u> , and that death occurred at <u>TP</u> M, from causes and on the date stated above.		22b. DATE SIGNED <u>1/29/67</u>	
22a. SIGNATURE <u>George J. Gonce</u>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. ADDRESS <u>Crownsville State Hospital</u>
22c. PHYSICIAN'S NAME (Type) <u>G. BENEDICT M.D.</u>		23d. LOCATION (City or Town) <u>Ritchie Hwy., A.A.C.O., Md.</u> (County) <u></u> (State) <u></u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-1-1967</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Cedar Hill Cemetery</u>
24. FUNERAL DIRECTOR <u>George J. Gonce-4001 Ritchie Hwy., Baltimore</u>		ADDRESS	25a. REC'D BY REGISTRAR
			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

00187

CERTIFICATE OF DEATH

00189

1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>A. Arundel</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>		c. LENGTH OF STAY IN lb <i>7 days</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>		d. STREET ADDRESS <i>208 St. James Drive</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>208 St. James Drive</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>ALBERT GEORGE WALKER</i>		First <i>A</i>	Middle <i>G</i>
4. DATE OF DEATH <i>January 18 1967</i>		Month <i>Jan</i>	Day Year <i>18 1967</i>
S. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>9-14-1886</i>	9. AGE (in years last birthday) <i>80 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Retired</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Oxford, England</i>	
13. FATHER'S NAME <i>George Markim Walker</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Osborne</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-18-7744</i>	17. INFORMANT Address <i>Mrs. Edmondi Wright Rt. 2 New Windsor, Md.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>H20.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Generalized arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Cerebral hemorrhage</i>	
(b) DUE TO <i>Arteriosclerotic heart disease</i>			
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>July 16, 1964</i> , to <i>Jan. 18, 1967</i> , that (I) (we) last saw the deceased alive on <i>Dec. 18, 1967</i> , and that death occurred at <i>8:20 AM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Edmond I. Moushabek</i>		22b. DATE SIGNED <i>1/21/1967</i>	
22c. PHYSICIAN'S NAME (Type) <i>EDMONDI MOUSHABEK</i>		22d. ADDRESS <i>S 10 MARLEY STATION Glen Burnie, Md. 21061</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1/21/1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Taylorsville Cemetery</i>
23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <i>C. M. Waltz Box 241 Sykesville, Md.</i>		25a. ADDRESS <i>None</i>	25b. REC'D BY REGISTRAR <i>Carroll Co., Md.</i>
25c. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>		DATE JAN 23 1967	

02100

02100

LAND OWNERSHIP RECORDS OF THE STATE OF KANSAS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00188

00190

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANNAPOLIS 39 DAYS		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) NAVAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RICHARD First Owen Middle WILLIAMS Last		4. DATE OF DEATH JAN 8	
5. SEX MALE 6. COLOR OR RACE CAUC 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED 18 MARCH 1879 9. AGE (In years last birthday) 87 yrs.		Month Day Year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NAVAL OFFICER RET		10b. KIND OF BUSINESS OR INDUSTRY U. S. NAVY	
10c. BIRTHPLACE (County & State, or foreign country) PEN-Y-CHOE		12. CITIZEN OF WHAT COUNTRY? CAENARVANSHIRE, N. WALES USA	
13. FATHER'S NAME WILLIAM EVION WILLIAMS		14. MOTHER'S MAIDEN NAME SARAH FOOD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES 1895-1930		16. SOCIAL SECURITY NO. 220-44-0699 17. INFORMANT DOROTHY K. WILLIAMS 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH	
Cconditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 27 NOV 1966 , to 8 JAN 1967 , that (I) (we) last saw the deceased alive on 8 JAN 1967 , and that death occurred at 207A , from the causes and on the date stated above.			
22a. SIGNATURE <i>L. W. Johnson</i>		22b. DATE SIGNED 8 JAN 1967	
22c. PHYSICIAN'S NAME (Type) L. W. JOHNSON LT USNR		M.O. ATTENDING PHYS. <input type="checkbox"/> M.D. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS NAVAL HOSPITAL, ANNAPOLIS, MARYLAND	

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1/11/67		23b. DATE THEREOF 1/11/67		23c. NAME OF CEMETERY OR CREMATORIAL U.S. NAVAL ACADEMY		23d. LOCATION (City, town or county) (State) Annapolis MD	
24. FUNERAL DIRECTOR John M. Fogors		ADDRESS Say Annapolis, Md.		25a. REC'D BY REGISTRAR JAN 12 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	
VR A15 (4) 20M 1/65				DATE			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00189

CERTIFICATE OF DEATH

00191

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND ANNE ARUNDEL								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS, MARYLAND		c. LENGTH OF STAY IN 1b 13 DAYS								
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) NAVAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) EMILY H. WINTERS		First	Middle							
4. LAST		5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. FUNDER 1 YEAR	11. FUNDER 24 HRS.		
		FEMALE	CAUC.	WIOOWEO <input checked="" type="checkbox"/> DIVORCEO <input type="checkbox"/>	JAN. 17, 1891	75 yrs.	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (County & State, or foreign country) BELLEFONTE PA.		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME FRANK PECK BASSETT		14. MOTHER'S MAIDEN NAME MARION HUGH BASSETT		Address 3757 PEACHTREE-CAPT HUGH WINTERS USN/RET DUNWOODY RD.						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).1] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RENAL FAILURE 593X Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) CONGESTIVE HEART FAILURE (c) 				
OUE TO		OUE TO		OUE TO		INTERVAL BETWEEN ONSET AND DEATH				
20a. ACCIDENT WAS UNDERRYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.O. ATTENDING PHYS. <input type="checkbox"/> 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) L. W. JOHNSON LT MC USNR	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 26 DEC 1966 , to 8 JAN 1967 , that (I) (we) last saw the deceased alive on 8 JAN 1967 , and that death occurred at USNH ANNAPOLIS, MD. from the causes and on the date stated above.		22d. ADDRESS John M. Taylor & Sons Annapolis, Md.		23c. NAME OF CEMETERY OR CREMATORIAL Et Lincoln		23d. LOCATION (City, town or county) Bladensburg Md.				
24. FUNERAL DIRECTOR John M. Taylor & Sons Annapolis, Md.		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE		DATE JAN 12 1967				
20A 15 (4) 20M 1/65										

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH				00192			
1. PLACE OF DEATH a. COUNTY			Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md			b. COUNTY A A Co										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Riviera Beach							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			Riviera Beach			d. STREET ADDRESS			d. STREET ADDRESS			Riviera Beach							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			8108 Ft Smallwood Rd			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			8108 Ft Smallwood Rd							
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH			Month	Day	Year								
Female			Ella	E	Yearsley	Jan	20	8:PM	19	67									
5. SEX			6. COLOR OR RACE	7. MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.							
Female			W	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	Feb 18, 1890	76	Md	Md	USA	Yrs.	Hours	Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME			Solomon Messick			14. MOTHER'S MAIDEN NAME			Ella Hatton										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			(If yes give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			Address							
No									Family			Same							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of right breast metastases</i>												9 years							
170X Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)										
21. I certify that (I) (this hospital) attended the deceased from Oct 6, 1950, to 19, 19, that (I) (we) last saw the deceased alive on 1/18 1967, and that death occurred at M, from the causes and on the date stated above.																			
22a. SIGNATURE <i>Sidney R. Gehlert</i>												22b. DATE SIGNED 1/23/67							
22c. PHYSICIAN'S NAME (Type)			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22d. ADDRESS													
Sidney R. Gehlert, M.D.						4700 Pennington Ave. Balt. 26.													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 1/24/67			23c. NAME OF CEMETERY OR CREMATORIAL Glen Haven			23d. LOCATION (City, town or county) AA Co Md			(State)							
24. FUNERAL DIRECTOR McCully F H 237 Patapsco Ave			ADDRESS 21225			25a. REC'D BY REGISTRAR DATE JAN 24 1967			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>										

SE100

STAND OF GUARDIAN

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Robert Anti

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Water Service

Water System

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34' - 30' S.D.

X 30' - 28' S.D.

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Ground

Ground 30' S.D.

Ground 30' S.D.

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